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CHAIR HURLBURT: We try to get started on time and keep on schedule. So just about everybody is here. I'd like to welcome everybody this morning again and thank Deb for getting breakfast for us again there and coming in earlier yet to do it.

The first couple of hours, we're going to talk about evidence-based medicine. That's something that I have a fair amount of passion about since I got involved in it. It's not a totally new concept. For the majority here on the Commission who were here last time, I did talk about this and you'll see a few of the slides are repeated there, but this will go into a little more in-depth discussion. I'm not trying to make anybody experts on evidence-based medicine, but I will present some detail about the how-tos and the components of it. There is a lot of potential there and a lot of need, I think, as far as improving quality. I think as far as what I see as the role -- and I'll come back to this in one of the last slides there for this, but it's to understand the potential that is there in evidence-based medicine and to consider whether it's something that, as a Commission, we want to adopt in the recommendations that we make to the Legislature, to the Governor's office as far as something the State can use where the State serves as a payer, recommended

for others in the State as a way both to improve quality and to assure the appropriate utilization of resources.

I'm going to stand up and do this and use the slides. So first, am I okay sound-wise to do this?

MADAM COURT REPORTER: Now you will be.

CHAIR HURLBURT: I'll probably move a little bit but be similar to last time. The definition of evidence-based medicine, evidence-based medicine aims to apply the best available evidence gained from scientific method to medical decision making. It seeks to assess the quality of the evidence of the risks and benefits of the treatments, including the lack of treatment. And this is from the all-knowing source Wikipedia, but it's a pretty good definition that we have there.

And I'm going to use a lot of examples as I talk through this. A recent article this month from *Wall Street Journal*, the Chief of the FDA describes the problem we have nationally with increasing antibiotic resistence. The FDA is now seeing resistence for virtually all antibiotics. And increasingly, we are very limited in the ways that we have to treat serious disease when there is that resistence there. Clearly the use of antibiotics has to be much more judicious. The comment from the FDA leader was, the drugs have almost been routinely been used in recent years for common colds and ear infections where there is no indication for antibiotics. And this is not

just physicians doing bad things. Often times, it's, you've got to give little Johnny antibiotics. I know he's sick, and you're busy, and you've got to get on to the next patient, or you know if you don't it, they're going to go down the street to Dr. Smith, so there's a lot pressure there.

And it's not just the United States. I spent a couple of years in Liberia and West Africa leading a time where we were developing a physician assistant based rural health care program. We were in one of the nine counties in that country, and it was clear to me there that the administration of medicine, particularly shots, was a real opportunity to exercise power. And so the physician assistants that were there in this rural country -- in some of the villages, we had to walk the trails into. We had a military contingent there. They flew me in to some of the communities. That was a real educational challenge to educate these folks that you don't just give a shot as an exercise of power or because it's your cousin or because it's your friend, but you give it on an evidence-based decision making way.

Well I'll take the risk of talking about my neighbor here and his Union.

UNIDENTIFIED COMMISSIONER: We prefer guild.

CHAIR HURLBURT: Most urologists clearly would recommend PSA tests, and I suspect most of the males in this room do take their physicians' advice often and receive PSA tests.

I'll be up front and say I do not have my PSA tested, so I am convinced by the evidence on that.

This was an article again this month from the *San* Francisco Chronicle. Sadly most men are never told the facts about their tests, nor are they encouraged to make their own informed decision. I actually think that probably the best thing is for the physician and the patient to have an enlightened discussion and present the evidence, and like so many things in medicine now, it's a collaborate decision. The physician is not God the way I used to be more, I guess, but the decisions are more collaboratively made which is a much better way to do things than talk about it. But most men that are treated would have been fine often without the -- if they never even knew about the cancer. So there is excessive treatment there, and I'll give you some numbers later on about the numbers that are treated to maybe do good for one patient there and the cost of that.

So there are harms by the tests. And these are a couple of large studies; 162,000 from Europe of men 55 to 69, 1,400 would need to be screened and 48 additional cases of prostate cancer would need to be treated to prevent one death. There is a high risk of over-diagnosis through the use of PSA tests there. In the American trial, 77,000 men 55 to 74, there was no overall reduction in mortality in the screening arm compared with a comparable sized group that did not have PSA

testing done.

The Uncritical Use of High Medical Technology Imaging. As a surgeon, I've said, at times, it seems like CT scans have replaced hands. If you come in with right lower quadrant pain, pinpoint tenderness, rebound tenderness, high white count, good story for appendicitis, we used to be able to diagnosis that, but now you're pretty much going to get, sometimes, an ultrasound hopefully. Now it's kind of coming around a little bit by the recognition of the dangers of the radiation exposure from CT scans. But in many ways, CT scans in that setting did replace hands.

Well for a number of years, the biologic drugs in the pharmaceutical business were the highest growing, fastest growing component of health care. That has been replaced by some of the diagnostic imaging modalities now. And there is wide agreement that many of these diagnostic imaging tests are not necessary and a lot of the practice is driven by habit. It's driven by anecdote, and it's driven by tort fears. By fears of if I don't do it, am I going to be sued because missing a diagnosis is one of the most common things for which a provider can be sued.

A *Scientific American* article again this month, a new study shows that for life-threatening injuries, a three-fold increase in the use of CT and MRI scans in the emergency rooms has resulted in no improvement in the diagnosis of injuries in

that setting. And many of you have seen the projection that the use of CT scans as it has increased over the last 30 years now presents a significant risk. And picking one year from this particular study out of the *Scientific American*, in 2007, CT scans in America will cause 29,000 additional cancers that would not happen if we did have that CT scanning capability, and I'm not saying it's a bad capability. You know, it's a miracle, like so many things that we have in medicine, in what it can do and in many other of the diagnostic modalities as well as therapies. But we tend to use them. We invest the money. We buy the equipment. Obviously we have to use it to pay off this big capital expenditure and for all the other reasons that I mentioned we use it. So that's been a problem.

Here's a *Washington Post* article back from a couple of years ago. The number of CT scans performed in the United States has increased, rising from three million to 67 million in 2006. Now this is because it was a newer modality. It was more of available, but it wasn't many years ago that there were as many CT machines in Oregon as there were in Canada. We really -- we like our technology in this country, and we jump on the bandwagon and we use it. There has been a big increase -- the average radiation exposure due to CT scans has increased 600-fold over this 30-year period. So it's significant exposure.

Another study, the other topic, this is from a *Wall*

Street Journal article last winter. This has to do with cardiac patients who receive stents. Now this refers to about one-third of the patient population that receives stents for their cardiac artery. Not all patients are receiving those stents. This third of patients are those who have what is diagnosed as chronic stable chest pain. It's a five-year study. They compared the use of patients treated with drugs and compared it with those treated with intervention. And as Noah told us yesterday, in ten minutes, he made what he made all day long by doing the interventional thing because that's the way our system reimburses.

Well this study was published back in 2007 in the *New England Journal of Medicine*. And the Boston Scientific who made the stents, their stock took a hit. The number of stents dropped off, but it very quickly came back and we're doing about a million a year now. Dr. Boden who wrote the article said, what we're doing continues to drive -- what drives practice is reimbursement. If we just use the evidence for this one-third of the patients who are inappropriately getting these cardiac stents, that alone would save our country $5.0 billion a year.

Health Affairs. This is comparative effectiveness research. It's a newer term. The evidence-based medicine is a concept that goes back -- really the father of it -- and I'll mention his name again later, Dr. Sackett out of Canada

who initially described it and published articles about it in 1972. There were other pioneers in the United States, in Australia, in Europe. But pretty consistently, evidence-based medicine was felt that, to really use those concepts, you should not look at issues of cost. So for instance if you had a pharmacy and a therapeutics committee that was using evidence-based medicine to decide whether you would add a new therapeutical interventional agent, a new drug to your formulary, you would not look at cost on that.

The comparative effectiveness research brings in the concept of cost, and I'll give some examples that blow my mind, at least, later on why it's important to do this. So this concept of paying -- if you're going to have equal results from two different interventions and one intervention costs ten times more, that's something that you need to look at, as long as you're doing the thing that gets the best results for the patient. So it's not about saying no. It's more about saying yes that this has to do with the comparative effectiveness research or yes and a concept -- now it's infinite wisdom, Congress decided -- and I had the light turn on last night as I was reviewing this.

The reason the name changed from Patient Protection and Affordability Care Act that now it's talked about, at least by the supporters, as the Affordability Care Act is because the law contains a provision that the comparative effectiveness

research cannot be used for Medicare patients. So Congress, in its wisdom, decreed this. Now you know like so many things, it was well-intended that you're not going to have rationing or you're not going to have these other things there, but the result is to say you can't use this kind of scientific evidence and we decree that that's the way medicine is going to be practiced. But I think you know hopefully, we'll see that change because that is so patently absurd. In the, I think, the upcoming, the next issue of the *New England Journal*, there is an article addressing this and addressing the absurdity of this, but I think maybe that's why they dropped Patient Protection from the title because that didn't make sense.

Now this is from the *Fiscal Times*. The authors' proposed pricing method leaps over the roadblocks. This talks about using the comparative effectiveness research there, how it's been prohibited from CMS from using that for technologies that are approved.

Now this is the example that the I have before, but I like it and I'll use it again and I've used it a few times. And the last time, we had kind of a test so I was going to see how Jeff remembered that there. But the question is, who killed George Washington?

COMMISSIONER DAVIS: His doctors.

CHAIR HURLBURT: His doctors, exactly. And these were

country bumpkin, weren't they, his doctors? No, they weren't. He had four physicians that were called in to see him. Three of them had graduated from Edinburgh which was, at that time, the preeminent medical institution in the English-speaking world, and one of them was from Jefferson in Pennsylvania, Philadelphia, one of the top medical institutions probably along with Harvard and Yale at the time in this country.

So these were the four physicians who came in, and he was sick. He had been out working in his field. He wasn't feeling good. He didn't want to bother his doctor. You know, I don't want to get him up at night, but he finally prevailed on his wife and his servants there to call the physicians. So they came in, and indeed, he was sick. So well, what are we going to do? Well we need to take some blood, obviously. This is a serious case. So they took some blood, and he didn't get better. Well they didn't give enough treatment. We need to take some more blood, and they took some more blood, and they took some more blood. And they consulted together, and these were eminent physicians. And they did some things in addition to taking the blood. They burned his neck. They gave him calomel, which is a mercury containing compound that has been used as a purgative but probably induced some poisoning. And he died peacefully. Well when you're in shock, you normally die peacefully. But this is what happened to the father of our country who thought he was

getting the best things, and I can't tell this story -- and now we have a third lady member of our Commission here.

So the footnote of the story is that, while George Washington was really supportive of bleeding and had used it among some of his slaves and his servants, Martha was very much against it and she thought it was a bad thing to do. So the moral of the story is, for guys, listen to your wives on that, but that's what killed the father of our country. They thought they were doing the right thing.

How about some other examples? Vioxx. Vioxx has been removed. This was an anti-osteoarthritis drug used for menstrual pain, for symptoms of rheumatoid arthritis, was quite popular. It was removed from the market by the FDA finally because of the concerns that it was raising the risk of heart problems.

Now Vioxx was placed on the market in May of 1999. At that time, I was Group Health. I co-chaired our Technology Evaluation Committee, our P&T Committee, Pharmacy & Therapeutics Committee that set the formula for that organization, reported to that group. We never put Vioxx on the formulary there because that evidence was there right from the beginning, and there were some others. I think Jeff said Premera did the same thing. But it was widely used. You never used it in your practice?

COMMISSIONER LAUFER: I was not a heavy user but I still,

monthly at least, have people say, hey, you've got some samples around; that stuff is great. You know, that's the only thing that ever worked for me. And no one has ever said I can't believe that it was that. So the patients who would guide me as a businessmen (indiscernible - simultaneous speaking).

CHAIR HURLBURT: Yeah, and I think that's an important point because there is nothing we do as physicians, nothing really, where there is not potential harm or potential good, and you weigh that. And if Vioxx had been used in that way, where it was effective for some symptoms, but if it had been used judiciously and in a limited way, it would probably still be available. But when it's all over television, go ask your doctor for Vioxx, the harm began to outweigh the risks there.

COMMISSIONER LAUFER: Lots of free samples.

CHAIR HURLBURT: Yes, yeah. Avandia, this year's example, a diabetic drug that came out again has been limited in its use here because of the increasing risk of heart problems. This I read. I'll read it again.

David Eddy, who was from the University of North Carolina and in the United States was an early guru of evidence-based medicine, was Vice President with Kaiser for a number of years, now has his own firm and is a physician, wrote an article again *Health Affairs* about five years ago.

Up until about 40 years ago, medical decisions were doing

very well on their own, or so people thought. The complacency was based on a fundamental assumption that through the rigors of medical education, followed by continuing education, journals, individual experiences, and exposure to colleagues, each physician always thought the right thoughts and did the right things. The idea was that when a physician faced a patient by some fundamental human process called the "art of medicine" or "clinical judgment," the physician would synthesize all of the important information about the patient, relevant research, and experiences with previous patients to determine the best course of action.

Well at one point, that may have been valid, but in some ways, knowledge is like a lake. We have had such incredible expansion of knowledge, and the unknown is the shore. So the bigger the lake gets the bigger the shore is, and there is no way that somebody can walk around all the time and keep that in mind. It's why my own bias is -- as Noah and I were talking yesterday -- that his setting where he has a dozen physicians that are working together, you can bounce ideas off each other. You work as a team. You hold each other accountable and that's an advantage. You need access to the literature. You've got a patient that stumps you; I need to look up something about this. It can be formal things, which a health insurer can do or a state Medicaid payer or larger groups of physicians, and this is what needs to happen.

Now some examples from here. Again this is a repeat for some of you. When I first came to Alaska in the Bush among the Alaska Native kids -- am I doing that?

(Pause - background noise)

UNIDENTIFIED MALE: Whoever is online that hasn't had their phone muted, please mute it.

MADAM COURT REPORTER: Please mute it. If they'll just mute their phone, that will resolve it.

CHAIR HURLBURT: Thank you. That stopped it sounds like. Thanks. Pussy running ears were as common as runny noses among Alaska Native kids in those days and so the NIH, the Indian Health Service, got national experts together, pediatric otolaryngologists from the top universities around the country, and they said what should we do. Well we know what we should do. We need -- as soon as we can safely put these kids to sleep, we need to do a T&A, tonsillectomy and adenoidectomy.

So there were mass T&A clinics around Alaska. You went the village. You had a log cabin. You had a cot. You had a nurse anesthetist there. You would put them to sleep. You'd take out the tonsils and adenoids and get through that village and take off and fly to the next. A T&A is not tough surgery to do, speaking as a surgeon, but like anything else, there are risks. You can bleed afterwards. It was not a good thing to do, and it did no good. Now we don't see that now. We

still see probably more coracoiditis which is not pussy running ears, but somewhat more coracoiditis in kids than you do in the U.S. all races population, but we don't have that problem which was so common.

We had other things that the experts advised us to do. Noah will cringe when I describe some of the things that I did. We'd take and aspirate the pus out of the ear and we'd pack it with cholophynicoyl (sp) powder into the external auditory canal. Now this is serious disease because you can get what's called mastoiditis, inflammation of the bone right in back of your ear. It can go through and cause a meningitis, commonly cause deafness. So it was a real problem among the kids here, but it's much better now for all the things that the doctors did, like better housing, like water, like sanitation, like better diets and better income and those kinds of things, and a little bit of medical care. But it basically was changing the living conditions.

As a surgeon, what's the proper surgery for peptic ulcer disease? Well now almost none. Sometimes you may have bleeding that won't stop or you may have a perforation where you need to do surgery, but basically, it's not a surgical disease. It used to be much more so. It's not a surgical disease now because of the miracle of the newer drugs that we have that work so well. But back in the days when we did surgery for that, what was the surgery? Well just in my

career, it marched up and down the stomach. How much do you take out? Do you take none at all? Do you what we called the biotomy and a pyloroplasty? Do you take out half the stomach? There were fashions. We always believed we were doing the right thing, but there wasn't real evidence for that.

Another example from my specialty, a papillary carcinoma thyroid gland. Nobody wants to get a cancer at all. There are four main types of thyroid cancers, papillary, follicular, the medullary, and anaplastic. Most of them are papillary and follicular. For most cancers, you talk about five years no evidence of disease, thinking you've had -- are probably doing pretty good therapeutically on that. Well you can't talk about that with a papillary cancer of the thyroid because it's such a slow process there, but we went through phases. You do a subtotal thyroidectomy, a total thyroidectomy, take out one lobe and the isthmus, the bridge between the two lobes of the thyroid. We went through fashions, and it wasn't really based on evidence. It's based on what the experts were saying at the time. So these are just some examples from my own career.

Again definitionally, evidence-based medicine aims to apply the best evidence gained from the scientific method to medical decision making. It seeks to assess the quality of evidence of the risks and benefits of treatments, including the lack of treatment. Just repeating that.

So is the appropriate question, whose evidence? I would

say no. That's very clearly not the appropriate question. The appropriate question is, what is the evidence and how strong is it? There are statistically and scientifically sound really pretty widely accepted norms for grading the strength of evidence, and what do we mean by grades of evidence? Well I want to take the next few slides and pursue that a little. A couple other questions.

How and where are the principles of evidence-based medicine applied? And what should the health care system and health care providers be guided to do if they utilize evidence-based criteria? What are the recommendations for that?

Now the U.S. Preventive Services Task Force looked at grades of evidence, and you see the three grades there, five grades actually broken out with the sub-grades there.

The level one, which is the strongest evidence, is evidence that can be obtained from at least one properly designed randomized controlled trial. Now this is easier to do with drugs than it is with procedural interventional things. We don't like to do sham procedures. Put a cut on somebody and give you a scar and you don't know if you had the therapy or not, that's got some ethical problems to doing that and so we don't do that. It is easier to do with drugs.

What do we mean by a randomized controlled trial? Well the strongest evidence -- and the numbers have to be there.

They have to be able to stand up to statistical evaluation, and I'll talk a little bit about that. But if you have a trial where you have an intervention -- and it could be a test, a diagnostic test; it more commonly could be like a drug -- and you have two groups of people, one of whom receives a placebo, one of whom receives the interventional agent or the interventional test, and the patient does not know which group they're in, the physician or other provider administering the drug does not know which group their patients are in, and the evaluator does not know which group those patients were in, that's called double blinded, randomly controlled because the patients are randomly assigned to the intervention group and the non-intervention group.

So if you have a study like that that achieves statistical significance, as a general term, that's valid, that's your strongest evidence. Now sometimes you can't do that. So sometimes you really can't randomize your treatment, but if you have two groups of people that you can control for similar ages, similar co-morbidities, other diseases that exist in them, a similar gender breakdown, racial breakdown, economic breakdown, if you can control that without randomization, that gives you pretty good evidence, not as strong as the double blinded studies and so on. But I'll skip down to the last one.

The last one is the opinion of respected authorities

based on clinical experience, descriptive studies, or reports of expert committees. That's very weak evidence. That's highly suspect. That's threatening to those of us, like me, who consider ourselves experts in what we do, but that's not strong evidence. Sometimes it's all you have, and we'll talk about that a little bit later.

How do you apply this? You do the best you can. Now both in an organizational context, meaning like a payer or policy setting group, and in the individual provider to patient setting there. And sometimes as I say, that's what you have.

Well evidence-based guidelines at the organizational or institutional level means taking those guidelines, the policies, and the regulations -- it's evidence-based health care and you use that evidence and where you set those policies, where you say what's going to be on your formulary or not on your formulary and how hard is it to get an exception to the formulary that you do, or we're going to pay for this procedure but we're not going to pay for that one, we're not going to pay for going in and cleaning up your knee arthroscopically for osteoarthritis because, although it pays very well, it doesn't really do any good. And guess what? The orthopedists are going to say, come on, you're telling me how to practice medicine.

So that policy setting sets up some potential for

confrontation. If Jeff doesn't have Vioxx on his formulary and Noah has the best patient to use it, he is going to feel like they shouldn't be telling me what to do; I don't use this promiscuously. This patient needs it, but Jeff's system needs to be that it is a hoop to go through. But at least Noah can say, we've tried this; this is the reason I should do it. And particularly where they know Noah, he practices high quality medicine, then the policy needs to be able to change, that you can make an exception for that. That's at that level.

The other level is at the evidence-based individual decision making level, and this is where, as I described before, the physician or other provider and the patient are face-to-face. This should be the background of the decision making. As I said earlier like with PSAs, I'm convinced it's not the right thing to do, but it is so commonly done and most of my respected colleagues who are urologists would advise that I -- I'm not sure what you do, Paul, but most of them would. So I say the best thing to do is to present the evidence and make joint decision that you have there. I've made up my own mind what that decision ought to be, but you do need to have -- bring other factors in. Patients don't come in. They're not just numbers or coming in a black and white box, but each setting is a little different. But this clinical decision making should be underlying with evidence and with an appreciation of evidence and grades of evidence.

When I joined the Technology Evaluation Committee there as Co-Chair in Group Health, the other Co-Chair was a guy named Mike Stewart who was a physician who I learned immensely from and really got me interested and turned on to this there, and Mike was very good. He wanted me on it because of my administrative clout because of the position that I held, and I was delighted to do it because I just learned a lot and it was clearly the right thing to do. And as an organization, I think they did that very well, particularly in the primary care and secondary care areas. But one of the things we went through, they had statistical epidemiologists there. They had some staff to support it. They had Mike, and another doc was on it. So they had good support, and they would present a new technology and have a vote. And they would have, like, the Chief of, say, the OB/GYN would come in and want to do something. And they basically did not have the clinicians have votes. So I said, come on you know, that doesn't make sense, and the argument was, well, if we give them a vote, they're just going to vote to do what they want to do and it's not going to be supported by the evidence. I said, well, what's our outcome, where do we want to get? Where we want to get to is that physicians, that we as physicians have imprinted in our DNA the concept of understanding evidence and grades of evidence and do what we do. And Mike's a great guy. He said, you know, you're absolutely right. So he brought

more of the clinicians on as voting members to make the decision, and it's something that, I think, helped improve the quality of care that we had there. It was initially don't let those people make those decision, which was, you know, kind of dumb when you think about it, but we were able to turn that around.

Now in terms of categories of recommendations, there are several systems of categories of recommendations, but this is the probably the most commonly used one. There is an A, B, C, D and I.

For a Level A -- and I'll talk a little more in a bit about how you assign something to an A or another level, but there is good scientific evidence that suggests that the benefits outweigh the risks, and this is something that a clinician should clearly discuss with their patient, probably recommend to the patient, and make that decision.

For a Level B, there is at least fair scientific evidence that the benefits outweigh the risks and that would be recommended that that discussion be held. Now most payers, most insurance companies, most Medicaid payers will, without question, cover therapies that are determined to be A or B.

Level C, there is some evidence there. There is fair evidence, and it suggests that there may be benefit, but you really don't have enough evidence to make a call or it's not really statistically valid that you have that you have there.

It's kind of marginal. It's hard to make a clear call on that. And so then that -- from the clinicians' standpoint, that's their call. Should you discuss it? Well it depends on what are the other alternatives, what's the situation there, and that's a judgment call. Most payers also will look at that as a judgment call, and those are the ones where a decision may be made. Now if it's something small, they don't get into it. If it's something that happens in the office, they never get into that. But if it's like a major surgical procedure, it's going to be pretty costly where you have to say, mother, may I, and get a prior auth there. Most payers will look at those on a case-by-case basis.

On a Level D, the scientific evidence is pretty good, but it suggests that the risks outweigh the potential harms, and generally, clinicians should not offer that to the patients. Now too often your patient will come in and say I read about this or I saw it on TV or whatever and you can't avoid dealing with it, but there is not evidence there and not something that should be offered.

And then Level I -- and a lot of things fall into a Level I. This is just a lack of evidence there. You don't really know is it beneficial, is it not beneficial, or the harm is greater. And again this is useful role for the clinician to discuss as to whether or not that should be pursued, and hopefully, studies will be done, hopefully studies yielding

high grade evidence so that, on this particular issue, it can move off of a Level I.

Dr. Neil Calonge who is Chair of the U.S. Preventive services Task Force was up here a few months ago, and he talked about mammography for women. And for those of us who are state employees, we saw the email coming out saying that the local provider, the preferred provider with the State service is offering mammograms for all women 40 and up and encouraging people to go get it. That is not supported by the evidence. Now if you talk to Dr. Lori Bleischer, who is a very excellent, wonderful breast surgeon here, Lori feels it should be done; I know and she's a person I respect highly. I don't believe the evidence supports that. Our State Employee Benefits Board got onboard and were asking the state employees to do it at age 40.

So what Dr. Calonge said, if there evidence of benefit, do it. This is very simplistic, but it's what it is. When there is evidence of benefit, do it. When there is evidence of no benefit or harm, don't do it. And when there is insufficient evidence to determine if there is a benefit, be conservative but use individual discretion. But if there are harms or costs that outweigh the benefits, don't do it. So that's kind of a simplistic summary of what the use of evidence-based medicine is intended to do.

Now what are the steps for that? First you define what's

your question about the provision of a service. This is really tough for an individual physician to do or a small two-person practice. A larger group of physicians can get together and formalize this question or a payer, like a health plan, can formalize these questions. So then you define and you retrieve the relevant evidence. If you're a big enough company, you do it by yourself, but there are services. For instance, Hayes Directory -- this is back East. I think it's quite sound. This particular -- this is just an example, but they have other kinds of things that are much shorter. This is their directory, and this is on medications for pediatric bipolar disorder, atypical antipsychotics. They start out with an Executive Summary, and they will say -- they will grade it. And the drugs here for these indications are all graded. One of them is a C. Quadapine is hormonal therapy for adjunct therapy to the Villaprex for adolescents with manic symptoms and a diagnosis of bipolar disorder. Everything else is a D. So they say maybe in that setting you use it. These drugs are used a lot in this country now at great expense and at significant harm, but this is a resource.

As a member of Blue Cross Blue Shield, Jeff's organization has access to a central functioning that they have that they and Kaiser collaborated on out of Chicago that do that. There is the Cochrane Collaborative out of England that a lot of folks use and can tap into.

A larger company will often have your own capability through, say, a multi-state organization to make some assessments because not everything is going to be covered and you may be seeing something frequently, but you tap into resources. So you define the question and you get the evidence. You look at the quality of the studies because not all studies are good and there are some ways that you can judge that. I'll mention a little but not a lot about that.

And then synthesize and judge the adequacy of the evidence to make your decision. Look at the certainty of net benefit, the balance -- net benefit meaning balance of harms and benefits -- and then the magnitude and the certainty of that and give it a grade, A or B. Discuss it with your patient if you should go ahead or have a policy we pay for that; no questions asked. C, case-by-case basis. D, probably not. And I, again kind of a judgment situation and you try to avoid that as much as you can because you are flying blind a little bit.

Now I've got three slides here. Basically they repeat a little bit of what I said, but these are the grades of evidence with randomized controlled trials. Number one being the strongest with increased accuracy and predicting results and the weakest, number five, being the expert opinion, with these other things along the way. This is ideal, but you can't always get it. So then you may look at other things.

These are just reports of case studies. And again as Noah and I were talking a little earlier, it's well-known that, if a drug company funds a study with a new agent, if the results are favorable, it's going to be published. If they're not favorable, it will almost never be published and that's too bad because that does not really help in the quality of medical care.

So what do you look at to find usable medicine? Well you look at the design of the study, and this takes some expertise to do and I won't go into the details on that because the purpose is not to give you all new jobs doing this. But if you look at the studies with the right design, how well are they done? Are they valid? Again there's garbage. Even in some of the best medical journals, there's some garbage there. And then, three, now that you've found that they're valid, you get a yes down to there. How useful are the results? And the results aren't always useful.

So if you look at an article, say the *New England Journal* or *JAMA* or *Annals of Internal Medicine*, the title is helpful because it kind of steers you. That's something that I'm looking at. So when you go in to kind of access what's available, that's first what you do. An abstract can be helpful to tell you whether you want to review the article. Now it's awfully easy to take an abstract that long instead of a 20-page article when you're busy and it's already 11 o'clock

at night and you're about to fall asleep. But the abstract is not what you need. So you want to look at the body and at the tables in there and the results, but you need to look at that. Does it really tie to this? Again sure, it can be looking at the conclusions. That's not evidence. That's opinion there.

So as you look at an article, these are things that clinicians can be trained to do, that decision makers can be trained to do. The state of Washington has folks come in through their payers, their Medicaid, prisons, workmen's comp and others every year and put on a brief one or two-day seminar kind of keeping them up-to-speed in the decisions that they're making on this.

So take a hypothetical case, and this is how big of a difference -- you know, what is the difference, what does it mean to say? Well if you have condition X and you treat it with intervention Y, at the end of five years, 10% of those who are treated die from the disease and 15% do not die from the disease. And for the sake of simplicity, I'm assuming they don't die from something else which is never real life. But there if 15 die without the treatment and ten die with the treatment, you have a Relative Risk Reduction, RRR, of 33%. Not bad. What's the Absolute Risk Reduction? You have 90 alive instead of 85 alive. The Absolute Risk Reduction is 5%. So if you have a relative risk reduction of 33%, it can mean the difference in a cohort of 100 people of a difference in

ten dying and five dying, but a 33% Relative Risk Reduction could mean a difference between 40% dying and 60% dying or 10% dying and 40% dying with the converse being the opposite number being alive. They're all a 33% Risk Reduction. Depending on the harm that it does, depending on the cost -- and I'll talk about cost issues a little bit there -- your decision may be very different, your best decision on that. If you do significant harm and you're only making a difference to five people -- if your Relative Risk Reduction is only 5% there, your decision may be very different here where you only have 10% alive without treatment and 40% alive with treatment. The net benefit at this level is much greater than it is at this level. So that's one of the things that you look at there.

Another way of looking at that is the number needed to treat. And again it's a concept both for policymakers, like Jeff or clinicians like Noah or Paul or -- Larry's not here yet, but Larry -- oh Larry is taking his boards -- we've got to pray for Larry, I guess, today. He's getting his recertification boards.

In example A there with 5% Absolute Risk Reduction, you have to treat 20 people to benefit one. So if the harms are great, you may be harming 20 people to benefit one. On the C example there where the difference was 10% survival versus 40% survival, you only have to treat 3.3 people to benefit one

person. So that's a way of looking at that.

We talked about the double blinded, randomized controlled studies being the strongest evidence there. We take the evidence, we take the results, and you subject them to a statistical analysis. And there are simple ways to do this, and most physicians learn a little about simple ways. But when you're really looking at it seriously, your larger groups are where you have the resources, like Blue Cross might have. You want to have statisticians that look at this, and what we tend to look for is what we say a p value of .05. That means that your results have a 5% or lower than 5% chance of being just the results of happenstance. It's a 95% chance that the results are due to the intervention that you did, to the drug, to the procedure, or whatever.

The lower the p value is, like if you have a p value of, say, .001, that's pretty strong. It's pretty unlikely but not impossible -- but pretty unlikely that those events are just due to chance, due to happenstance. If you have a p value of .1, generally that would be called not statistically significant. Now it doesn't mean you totally throw off that knowledge because it means you can say there's a trending of the information. And so when Noah is faced with a dilemma of what do I, we've really tried everything, a basically healthy patient, makes other sense, that trending becomes a part of what we talked about. That's where you make the clinical

decision of what do we do, but he knows it's not statistically significant, but you don't have anything better to go on that. So we look at that. We look at the Relative Risk Reduction number needed to treat Absolute Risk Reduction.

Comparative Effectiveness Research, as I said earlier, brings in the concept of costs for alternative therapies. As I mentioned, evidence-based medicine initially stayed away from that, but we don't live in a world with unlimited resources. There is a box around our resources, and health care gets a big chunk of that box. In Alaska if we use Mark's numbers from yesterday of $7.1 billion currently, that's 23% of our state's Gross Domestic Product. That's a big chunk of our state's Gross Domestic Product there, and we want to use it as responsibly as we can, and I would say I'd like to see it lower so that we have that money for education and roads and other things there. But be that as it may, the resources are limited. So that concern and that issue led to the term of Comparative Effectiveness Research. And I'm going to talk about that the next several slides.

This is a real example. These are all real examples. Bob Svensson -- and his name was in the newspaper -- was an 80 year old with incurable prostate cancer. There's a drug called Provenge that was approved by the FDA for advanced prostate cancer, just approved six months ago now. It's given in one dose. The cost of that one dose is $93,000. Now the

studies show that, on the average if Bob Svensson receives Provenge, his life can be extended by four months. Bob elected to take the therapy because somebody is paying for it. But like a good Swede or whatever he was, Bob says that, "I would not spend the money myself because the benefit doesn't seem worth it." But as long as somebody else is, I'll take the $93,000 for the four months of average expected extension of life.

Revlimid is an FDA approved agent for relapsing multiple myeloma. It's costs $10,000 a month. The results are that, if you receive Revlimid plus methotrexate which is an older anticancer drug also used for rheumatoid arthritis and some other things there, with the newer therapy with Revlimid plus the standard therapy of methotrexate, the average survival time is 29 months. If you give methotrexate alone, if you give the older therapy alone, your average survival for these patients is a little over 20 months. So for $290,000 on the average plus administration fees, you're going to get an increased survival of nine months. That's a factor in your decision making.

Another example, Tarceva, FDA approved -- all these are FDA approved -- for pancreatic cancer. Not quite as expensive. This costs $4,000 a month for the drug, plus administration fees. Tarceva approved by the FDA for this indication is not an off-label use of the drug, but approved

for this indication, average survival 192 days. Average survival without the drug 180 days. So for $4,000 a month, you get an additional 12 days of survival. And this doesn't get into the issues of does the intervention cause some morbidity. These are poisons, all of them, that we give to patients there.

Erbitux, approved by the FDA for prolonging life for lung cancer. It actually prolongs it quite a while, but it costs between $300,000 and $800,000 per year to give this drug to lung cancer patients. There are tradeoffs. Can we afford that? It's an ethical issue and it's a financial issue both, but it's a reality that we deal with. We could way go beyond 20% of our 23% of our Gross Domestic Product for health care alone, if we just did everything possible for everybody that's available.

A common diagnosis now, rheumatoid arthritis. Been around forever. A lot of treatment forever. Aspirin. The newer agents, NSAIDS, that are available, Motrin, Advil, other agents there. Patient education, sometimes forgotten. Pain management. Low dose glucocorticoids. That's like the steroid drugs. The DMARDS which are the disease modifying anti-rheumatic agents, like the methotrexate that I mentioned. Others (indiscernible - voice lowered) that's not used any more for that, I don't think. There are agents like that, but then there are the newer biologic drugs which have come along

and which can be quite effective.

If you take a patient with rheumatoid arthritis -- and there's been a lot of change in the field, and Noah knows way more about this than I do because it's certainly not in the surgical area, but there has been evidence that early, more aggressive intervention leaping to higher levels of care may really help and help avoid the rapid progression of the disease. But if you use methotrexate -- and there's also a concept of a Quality Adjusted Life Year, a QALY, Q-a-l-y. It's a soft concept. It takes a fair amount of subjective judgment, but you do read about it in the literature and it is an attempt to incorporate in the concepts of quality of life with just being alive. There's a difference between me being up here talking about something that I'm fairly passionate about and me being alive in a hospital bed on a ventilator. So it's kind of the intent to incorporate that kind of a difference in there. But if you give the methotrexate, the cost of the drug is a little under $5,000 a year. If you add the newer wonderful biologic agents HUMIRA or Enbrel -- just a couple of examples; there are others there, and this is from an article in the *Annals of Internal Medicine* -- $150,000 a year. So when do you make that progression there, and how much can we afford to make that progression?

This is an example. A young man in King County in Washington who was 14 years old when I first knew about him

had hemophilia. And some hemophiliacs, fortunately a very small proportion of hemophiliacs, are resistant to the normal drugs. Hemophilia is a deficiency in the body's clotting mechanisms. There's a whole cascade of what are called factors one, two, three, seven, eight and so on that related to this clotting process that, you know, is one of the critical things in keeping us alive and getting through life as people. We're designed in this miraculous way now that we clot. And for some people, this doesn't happen and there's a deficiency in one of the clotting factors and they bleed if they are injured. Or if they fall on their elbow, they get a hemarthroses. They get a big swollen up elbow full of blood. A very small proportion of people are resistant to the agents, and none of them are cheap.

This young man was going to school. He was engaging in sports, and it was at his right to do. It meant that if he hit his knee, if he hit his elbow, he'd bleed. He was being medically managed by the Puget Sound Blood Center there in King County. They were doing an incredibly good medical job in managing this young man, but his drugs alone ran $2.0 to $5.0 million a year. Now does he have a right to go out and play football and impose this cost on society -- he was a Medicaid enrollee -- to do this? Even a company that was the size of our company -- and we had about 300,000 enrollees in Washington, about 1.2 million nationally -- this impacted the

bottom line of the whole company. It was a for-profit company. Fortunately, the CEO was a doc and he still thought like a doc, and I called him up and I said, you know, this patient is there. It's going to hurt our bottom line. You need to know about it. And he's responsible for the stock price of the company and that's a part of what he does, but he also wanted to know how he was doing as a patient, and I was kind of gratified to be working for a company that had that approach to it. But this young man lost his Medicaid eligibility at age 19, and we said, you know, we finally dodged that bullet.

Well then he went on what they call a Basic Health Plan in Washington in King County, and this is a plan for the near Medicaid eligible. The scope of benefits is way, way smaller than Medicaid. The scope of benefits for Medicaid is wider than anybody can buy, but this basic health plan is much smaller. But the decision was made that the company that I was with said we cannot stay in King County anymore. They no longer provided insurance. There are other issues related to PPACA that are driving those same kinds of decisions.

If you say you cannot exclude somebody with pre-existing, these are pre-existing people. So if you come up tomorrow and you've got 5,000 people you're insuring, it's going to drive everybody's cost $1,000 a year just to pay for that one additional patient that comes in. These are issues that you

have.

One of the things that we all learn in our medical training is *primum non nocere*, first do no harm. The first thing, don't do harm because all the things we do can do harm and do do harm. So I went through several examples here.

Bloodletting. When I was in school, I went to George Washington University. I'm proud of my school. It was a very good school. I was happy to go there, but we had a couple of neurosurgeons who were the national leaders in prefrontal lobotomy. These were people who had mental health problems, and what you did is you went in and whacked off a big chunk of their brain. And we said.....

COMMISSIONER LAUFER: 60,000 Americans.

CHAIR HURLBURT: Yeah, yeah. This was no better than the Salem Witch Craft trials, as far as I'm concerned. But at the time, those were the experts and we thought it was the right thing to do.

Thalidomide was given as an anti-nausea agent to women who were pregnant. Now fortunately this was one that the FDA never approved in this country, but in Europe, you had babies born, significant numbers of babies with what's called phocomelia. They would be born without arms or without legs due to this drug that was given for nausea in pregnancy. Now there have been subsequently, like leprosy, other uses for this drug that were there.

Vioxx, we talked about. Avandia. Just last week, Meridia, the new anti-obesity drug that laboratories had, was pulled from the market because it was realized there was an increased risk of stroke and heart attack from that. So these are all things. These are drugs. These are interventions, surgical procedures that physicians have done in good faith or that drug companies have fostered, and I think generally in good faith, that do no harm.

Society entrusts those of us in the health sector with a big portion of our national treasure. The costs of health care are placing a heavy financial burden on federal and state governments, on employers, on all third-party payers at least. So we need to assure that policy and clinical decision making considers these aspects of evidence-based medicine, of cost effectiveness that we have.

A little bit on the history here, and I'll wind down here fairly quickly and open it up. And I've got examples of almost everything that I've talked about here. I mentioned the history going back to 1972. This was Archie Cochrane in Scotland actually who published an article on *Effectiveness and Efficiency: Random Reflections on Health Services*, and this was where the concept really began and took hold. Dr. Sackett and Dr. Guyatt were the Canadians. David Eddy I mentioned. Anna Gordon in Australia. John Wennberg who was the one at Dartmouth who looked at even there in New England

where there were communities that were just a few miles apart, where there would be vastly different incidences, say, in back surgery or hysterectomy for the same kinds of patients. Huge differences. And that's -- his institute is still there, still very active, the Center for Evaluative Clinical Services.

There are a number of articles. There was an article in *New Yorker* magazine about a year ago, I guess, now looking at El Paso, Texas and nearby communities. Again vast differences in close geographic proximity of why do you have so much more back surgery or so many more hysterectomies or something else in areas that are close together.

Montrose, Colorado in western Colorado has received a lot of favorable attention, has one of the lowest costs of health care in the whole country. And basically there is one kind of dominant payer there, but essentially there has been collaboration with the local medical community and the control has really been with the local medical community in deciding we are going to practice evidence-based medicine here. They provide impressively high quality care for the people who live in Montrose. They probably have one of the happier communities of physicians in the country because the docs are really running this in collaboration with the payers. And again Noah and I were just discussing earlier my own experience -- where I've worked as a clinician; I've worked as

an administrator; I've worked on the health plan side -- is that if you have a large enough group of physicians to manage these decisions they can always make much better decisions.

Now we have the concept of an Accountable Care Organization, which is part of the PPACA, there and there's a variety. This can be anything from full risk, which is what Jeff's organization gets. When his members pay a premium, he then has full risk for all the covered benefits that they have. Or you can have risk for just like primary care. And the conventional wisdom is, if you have 1,000 patients, it's reasonable, it's prudent to take that risk and then make the decisions. And they are gradations in between, but there are other ways to do it, other than just taking a risk. You can incentivize based on quality. You can incentivize on utilization of resources. And we'll be hearing more about that, about Accountable Care Organizations. But my own experience is that where you have a group of physicians who are organized well enough and who have a strong medical leader, they will consistently make better decisions, have better utilization of resources than Blue Cross ever can or than I ever could when I was responsible for medical management with an organization. Most of the time, you don't have that. Now it has to be done prudently because if Noah's group of a dozen docs there were to take on that risk and to get beyond what they could manage, it could bankrupt them. So

there is risk to doing it, but there are benefits and rewards. And if you can structure it so that the physicians can really be the ones running that process, they are the best ones to make that decision, particularly when they understand the concepts of what we've talked about. They have spent the years and years going through training and acculturation and being on the front line that administrators, bureaucrats don't have. So these are some of the resources. I mentioned them there that are available.

So what's the role for the Health Commission? I think the role that we have is to understand the potential for enhancing the quality of health care clinical and policy decision making, not the nuts and bolts so much but what's the potential in this. And to understand the potential for evidence-based medicine and comparative effectiveness research for assuring that health care resources, this current 23% of our Alaska's GDP, 18% nationally, that they are used most effectively and efficiently and that the resources available achieve the greatest health good for all Alaskans, which is what we're charged with.

I think one of the things we should consider as Deb pulls together our annual report to the Legislature, to the Governor in January is whether we should recommend increased use of these concepts by Alaskan physicians and other providers, by health care facilities, by government and private payers.

We've got a fair amount of time left, but I did want to leave plenty of time for discussion on this. So thank you. Val?

COMMISSIONER DAVIDSON: So I guess the question -- I mean, there were some really interesting slides about sort of what the benefit is for extending life for -- you used some examples. And I guess as long as we're talking about sort of the full complement of costs for health care, I'm guessing -- I have no scientific research, but I'm guessing that if you total up the amount of money that was spent on researching and providing medicines for impotence and improving virility and how much money this country spends on Viagra, that would probably be -- that has nothing to do with saving somebody's life, but improving perhaps quality of life.

UNIDENTIFIED COMMISSIONER: Quality. It's all about quality.

COMMISSIONER DAVIDSON: I know. I understand. I hear you.

COMMISSIONER LAUFER: It's all out-of-pocket. (Indiscernible - away from mic) insurance covers, and the guys are more than happy to pay. Really. Unless you have.....

COMMISSIONER DAVIDSON: So I guess -- yeah -- so I guess I was talking about more on the research end and how those costs are paid for by this country. And if we're looking at the whole cost of health research which I thought was the

point of your slides, then that all contributes to the cost. And so all of those questions on the slides that you showed really bring the question of, who ultimately decides, under what circumstances, does it depend on who pays and who doesn't, and does it depend on whether it's somebody you know or not? And I think the point of your slides was really who is in the best position to answer those questions and how do those conversations occur, but it's more than just life and death. It's in a variety of other enhancements of life, whether it's what I mentioned earlier or cosmetic dentistry or plastic surgery or et cetera and et cetera, and all of those things contribute to the cost of health care in this country.

CHAIR HURLBURT: I think that, in fact, a little difference in what Noah just said -- yes, Viagra is paid for by some payers, including Medicaid in some parts of this country. Sometimes drugs are developed for one thing, and actually the drug that Viagra is can be a lifesaving drug for pulmonary artery hypertension. And then sometimes you notice other effects when you're giving the drug, and a new market is developed and was pursued, and which, of course, has been extremely profitable for Pfizer for example. But you're right. You know, how can we invest that much money in research, how can we pay ten dollars a pill or whatever, when for five dollars, you could save a kid's life from malaria in Africa to keep the mosquitos away from them when there are

still 300 million a year that get malaria? So yeah and I think that's an ethical issue, but to the extent that we can advise payers -- and I think we can particularly can advise state payers here -- use the ethical issues as a part of your decision making. What are we going to use the taxpayers' dollars for to support where it will do the most good for the most people and avoid what's frivolous or what's supported? That we can probably do. We probably cannot stop Pfizer from developing and marketing this amazingly expensive performance enhancing drug. Yeah?

COMMISSIONER ENNIS: I found the discussion of Montrose, Colorado interesting, and I wondered if you know about the patient response that occurred there in terms of patient education or patient buy in of this approach because it would seem that that would be an important element in that community's success.

CHAIR HURLBURT: From all I've read about it, it's really been embraced by the whole community, by the payers, by the physicians, by the hospitals, by the public, by the whole community. Now while decision making as a good thing is more collaborative now -- it's not you go to the physician and they're God and they make the decision. It's a collaborative decision. The physician is still the leader. They have the knowledge there. So I think as the physicians have set the tone for the patients, that probably was -- you know, it's

unlikely that the population, that public would initially set the tone for something. The physicians needed to be the leaders there, but I think it's been embraced. And from what I have read in terms of the overall provision of health care, financing of health care, it's a good example for the country to emulate. I'm sure that there are problems.

COMMISSIONER ENNIS: Were there any particular strategies used to reach out to the public? Again thinking in terms of Alaska, what could be emulated to educate and shape a different attitude about evidence-based medicine to the general public?

CHAIR HURLBURT: Noah?

COMMISSIONER LAUFER: I think the thing that happened in Montrose that was important is the doctors were able to get together as a group. It was initiated by the doctors and that requires a community that trusts one another. That's a big issue for us. We've been fairly isolationist and distrustful of the bigger entities in town, and I think for good reason, we don't want to be crushed and haven't been dealt with fairly. That is the biggest impediment to the community getting together and saying let's do this in a rational way. We have -- I think there are 27 different EMR vendors in Alaska, you know, that don't mismatch these. They're electronic medical records. Everyone, when they come to my office, they assume, oh wow, you can communicate. Well no, we

can't because Providence just changed their system to another one. They're the sole vendor. They're the ones who will sell it. We're really not interested in being their client, particularly if they own our data. You know, these are the impediments that prevent a community from working together, and they didn't have it in Grand Junction, Montrose.

CHAIR HURLBURT: Linda?

MADAM COURT REPORTER: You'll need to use a microphone.

COMMISSIONER HALL: I was going to let Wayne talk. One of the places that I've seen probably the most discussion of evidence-based medicine has been more a very strict company, vendor, ODS -- I can't even think of the other one's name. I should; I've read it enough. It's been in the worker's compensation arena where there has been a proposal, obviously an external attempt to do that, not prompted by the providers. And yet it's an area that, to me -- obviously, I deal in that area a lot, but I think we need to change the way we approach. And if there are ways to do that, I mean I think, it's critical that we change to that type of a model.

I really like this term comparative effectiveness research. If nothing else, it's a perceptual change. That we get away from an outside vendor doing it, it appears, to me, to a different thing. But I think it would really be a worthwhile thing. I think we're going to talk about goals for us to talk about how do we change the environment, the way we

all look -- whether it's the patient looking at, whether it's the provider community, whether it's the payer, how do we get to a different place where we look at those kinds of things, including costs? And you hit something that's very critical to me as I look at it. I mean, that's what I evaluate. The cost of the health care system is what I use. We approve Jeff's rates based on those things.

I listened yesterday to discussions about the cost of health care. It didn't hit as much of the utilization. We're seeing utilization impact that cost to a great extent. And until we get into evidence-based medicine or some other way, I don't think we're going to start to have an impact. So I mean, this is an area, to me, that, I think, is critical that we, as a group, look at.

CHAIR HURLBURT: Yeah, and we talked a little yesterday -- it was interesting -- along the same line. But in terms of utilization, there is utilization; there is utilization. If you look at the Premera numbers that Jeff has, inpatient hospital utilization is higher here in Alaska than it is in Washington. We know our Medicaid bed days are high here, but primary care encounter rates are lower here in Alaska. And so it's not utilization is something that the good is driving down. Generally a prudent buyer will want to see -- and obviously you don't want somebody going in just for a feel good every two weeks, but that's not going to happen. But

generally across-the-board if your utilization rate for primary care visits goes up, your other utilization goes down and you have a healthier population and you save a lot of these risky things that we do to people. Wayne and then Noah?

COMMISSIONER STEVENS: I was just curious if you've made this presentation in front of other medical professionals and what sort of reaction you're getting from the professional community who would be impacted this sort of philosophical change.

CHAIR HURLBURT: Noah?

COMMISSIONER LAUFER: I was just going to say this is not a new concept to me. I started residency in '97. It was a regular event for us, the same terminology. We did bi-monthly journal reviews using the same criteria. Currently for continuing medical education, the reading that I do is actually graded, and if it has a little evidence-based medicine, EBM, next to it, I get double credit for doing that. So this has been part of my training since I've been in medicine. It's not a new concept for us. It's just in primary care the limitations are severe because there just isn't a lot of evidence for most things. It costs a lot of money to do big studies, and it lags behind the reality of practice. Particularly the approval for payment of it lags. So for example, the hemoglobin A1C which is a standard measure of your average blood sugar over the last three months, I've

been doing that my whole practice. This last year, it was approved as a way to screen. You know, it's sort of amazing, to me, that it took a decade for the experts to catch up.

And there are a lot of weaknesses. Say you're looking at MS. I don't think MS is one disease. I suspect it's five or more. And if you do data, the evidence is obviously going to be confusing. But we still have the patient in the room now and I have 15 minutes to treat them.

So while I think we have to be guided by this, obviously we should be practicing rational medicine. It does have its limitations. The process could be supported with legislation, but the outcomes are flexible.

So the first lecture I had in medical school was half of everything you learn here will be proven to be wrong in ten years, but we don't know which half so you have to learn everything, and that's good. There are very, very few things that you could be dogmatic about in medicine, unless you want to have your foot in your mouth because it changes.

Hormone replacement therapy in women. When I graduated from residency, if I saw a post-menopausal woman and I didn't have her on HRT, I was a bad doctor and I would be told that by the insurer. If I do now, I'm a bad doctor. Well biological reality didn't change; the model changed. Paradigms shift, and we can't make that that more stagnant with legislated dogma. Sorry. I'll be quiet.

CHAIR HURLBURT: No, thank you. That's very good. I think yes, that I have had opportunity to do that. I would say that generally among primary care physicians there is a fair amount of receptivity and understanding. There tends to be less among the non-primary care physicians. Probably the higher your level of income the more resistant you are to being challenged as the expert there. That's kind of a pejorative statement, I guess, but I think there is some truth in that. And I think that younger physicians clearly are going to be more understanding because it is being incorporated more and those that are my generation are going to be more resistant there.

I think the ideal, as Noah described, is if the physicians can be the leaders, as they were in Montrose, but I'm cynical enough to really think that the payers need to embrace it and be a driving force there. And for instance, the hemoglobin A1C in terms of -- and it almost fits in this Accountable Care Organization kind of thing, but I think a prudent payer, whether it be the State's Medicaid program or whether it be the Blues, probably should look toward rewarding the clinicians who meet certain targets as far as determining the hemoglobin A1C maybe as a first step and even thinking of, well, then do you get it below -- what percent of your patients, do you have it below 6.5 or 7? It's a proxy. Who cares what your hemoglobin A1C is, but what we're talking

about is you do care what's happening 15 years down the road and you want to know how many people have gone blind, how many have lost their legs, how many have lost their kidneys, had a transplant, gone on dialysis, how many have had heart attacks. So it's a proxy for that, but we believe it's a good proxy. And a lot of the things that we measure are proxy measured. So I think, you know, that the clinicians and the payers need to embrace that and incentivize this kind of thing so that physicians are rewarded for doing the right thing, which we just heard described. Paul?

COMMISSIONER FRIEDRICHS: Yeah, I think a couple of comments on that. Your somewhat tongue-in-cheek comment about specialists is perhaps penning not a completely accurate picture. It's very difficult to go in.....

CHAIR HURLBURT: I can say it because I'm a surgeon.

COMMISSIONER FRIEDRICHS: Well you know and that's exactly what I was going to say. It's very difficult for either of us to say, hey Noah, can I operate on you to see if you this works? Most patients object to, you know, yeah, go ahead; take half my brain and see if I'm better. You know, those are difficult studies to do and so doing a double blind trial on brain surgery -- very difficult for the surgeon not to know if he did the surgery or not. And so it becomes very difficult to build that.

Now I'll tell you having just, you know, been the big

international urology conference a few months ago where it is possible to do those trials. Increasingly across the practice of medicine, those trials are being done because people recognize that that's where we ought to be heading. The real lag, I think, is exactly where you said, that the reimbursement structure runs absolutely counter to the concept of evidence-based medicine. The reimbursement structure is geared towards utilization, not towards outcomes, not towards benefit to the patient, and that's the opportunity that exists today.

And Montrose is an interesting place to pick. If you've ever driven through Montrose, it's a beautiful little town in western Colorado. It's an idyllic place. Almost as nice as Alaska, but you know, it attracts people who like to live in a beautiful setting that's sort of away from everything. You can eat granola, hug a tree. It's all good. You know, that's not reality. That's not the way that the majority of cities or communities in the United States operate. People live there because that's the only place they could find a job. You know, Newark is not Montrose. You've got to build a system that's based on reality.

The Veterans' Affairs Administration actually was recognized by the Institute of Medicine as the best health care system in the United States today from an outcome standpoint. In fact, there is great evidence that shows that,

if you want to get the best care in the United States, go to a VA clinic. Go to a VA hospital. They have adopted evidence-based medicine now, going back to when Ken Kaiser was head of the VA -- another physician -- back in the mid-1990s. And in fact, they've restructured their entire health care delivery system so that, if I am sitting in a clinic seeing a patient, I get a little prompt on the computer that says, Dr. Friedrichs, this patient that you're seeing hasn't had his hemoglobin A1C. You should order one. And if I don't order it, that prompt keeps coming up; dummy, you still didn't order the hemoglobin A1C.

What they've also done is they've linked the bonuses to that, and they've allowed the physicians to say that this year we want, you know, the following however many measures it is to factor into our pay. And if you meet the benchmarks that the team agrees on, then you get more money. And if you don't meet those benchmarks, you get less money. Amazingly enough over time, that shaped the practice of physicians and nurse practitioners and others by linking what you're paid to what you do. And what you do is driven by the prompts by the system creates for you.

So there is a great model out there. It's the largest health care system in the United States today, but it's a very different model than the one we're looking at. And I think the real question for the Commission here is, what are we

trying to accomplish here in Alaska? If the goal is just to control costs, that's one discussion. If the goal is to control costs and improve quality of care, that's a different discussion. If the goal is to be on the cutting edge and come up with a model that builds a health care system that will attract people to Alaska, that will help Alaska to grow as a state, that's yet another discussion. So I guess my real fundamental question as I listen to this is, this is motherhood and apple pie. No one, I think, on the Commission is going to say we want bad quality medicine. That's not our recommendation is doctors should be bad. But what are we really trying to accomplish as a Commission?

CHAIR HURLBURT: Jeff?

COMMISSIONER DAVIS: Thank you, Ward. Thanks for the presentation. A couple thoughts here. I could go on, but I won't.

First Margaret Thatcher is quoted as saying that the problem with socialism is eventually you run out of somebody else's money, and I think that we're facing in medical care is that, you know, we're running out of somebody else's money to spend on these things.

And you know when I was in graduate school in 1982 at the University of Washington, it was like, oh my gosh, you know pretty soon, we're going to be at a 10% GDP and the sky is going to fall. Well it didn't, but I know my clients and

Wayne's constituents and the State government and your people that you're asking for money from Washington D.C. are saying, you know what, we've just about had enough here. You know, $500 per month claims' costs, are you kidding me? We can't support that anymore.

So we have to make some choices. You know when money is flowing into your home budget, you can go out to dinner. You can do this and that. When things start to get tight, you have to say, whoa, do we do this, do we do that. And I don't -- you know, another famous quote of Curly in, you know, *City Slickers*, there is one thing. Well in the solutions to the issues that we face, there is not just one thing. But I think what you have described is an important thing, and it doesn't -- it will never apply to everything. You know, they'll never replace clinical judgment. But you know, the examples around the drugs are really striking.

I've got a 10,000 member individual block of business with roughly $10 million a year in premium. That one young man joining that pool under PPACA as an 18-year old with no pre-existing condition exclusions and guarantee issue, the rates just went up 50% for that pool. You know, that's the reality that the people who are paying their own coverage or the employers who are paying are facing.

So it is -- you know again, this is not the panacea, but I think this is -- it is very clear it is motherhood and apple

pie. There are examples where evidence-based medicine is not being applied, and we need to do, I think as the Commission, what we can to figure out how can we make that work as part of creating a different system that Valerie talked about yesterday and you mentioned this morning. And if we can do that, you know the Alaska version of Montrose, then we've done a service for our constituencies. But there is not -- we cannot continue to pay for everything for everyone just because one person decides they want it or Mr. Svensson says, hey if it was my money, I wouldn't spend it, you know but since it's yours, I will.

The pipeline of biological drugs is just starting. If I've got the numbers right, I think it's about 1.5% of -- or less than a percent of the prescriptions that we pay for, but it constitutes 15% of the total pharmacy costs today and that's just the beginning. That is really ramping up. So I appreciate the comments and I would encourage us not to, you know, pick around the edges, but if 80% of what we've said today has some application, then great and let the other 20 fall where it may. Thank you.

CHAIR HURLBURT: Yeah. And I'd say my response to Paul's suggestion is that our opportunity as a Commission is to try to assure that we deal with the second rather than the first and that if we don't embrace and deal with the second, i.e. combination of cost and quality, sooner or later -- and it

wasn't at 10% and it wasn't at 18% yet, but sooner or later, others will deal with it from the first perspective. And then there's the added dimension that I kind of brought in, just on the cost issue is the ethical implications where we are growing at 20% to 25% a year on the cost of the biological agents, and if you could invest your life savings at that kind of a compound interest rate, you could retire as a young person. But that is a part of the ethical dimension. Can we afford to pay half a million dollars a year to keep somebody with a lung cancer alive and how many people can we afford it for? We can probably afford more than most places in the world, but there is a limit. But I think our opportunity and our need and the hope on the part of both the Legislature and the Governor is that we can embrace and deal with it from the perspective of your second point.

COMMISSIONER FRIEDRICHS: And I may then, if indeed that's the case, then a blanket adoption of evidence-based medicine will not achieve that balance that you're describing and that's the caution that I would drive the Commission towards is evidence-based medicine is motherhood and apple pie. You know, there's no doctor who will stand up and say I'm very proud that I have not a read a journal in the last year; I don't know what the new therapy is and I'm not going to use it. I mean, you won't find them out there. What you will find is people who are struggling with that balance and

so if we as a Commission then say, well you know, we really need to bring evidence-based medicine forward as one of the things that we are going to espouse, in what context? And I think that's where I'm struggling a little bit to shape. Are we going to use what the prior Commission came up with as our framework and accept that those are the goals and then we flesh those out, or are we going to revisit for this report that is going to come out in a few weeks here really -- are we going to revisit what the overall tenure of the recommendations will be? Because if it's that we accept the work that's been done and we're going to flesh that out further, then yes, this is sub-component of the work that's already been done. If we want to revisit the overall thrust of health care delivery in Alaska, then there may be benefit in looking back at those fundamental goals and objectives.

CHAIR HURLBURT: Noah?

COMMISSIONER LAUFER: I apologize for talking too much, but I think an attainable goal, because it's very low-hanging fruit, is diabetes and it doesn't require a lot of hard thinking. It's actually just an organizational problem for most patients and their physicians.

When you guys ran an ad for your new clinic and talked about how you were the best at it, I thought, oh man; I was really envious. That's great and it's something that the SouthCentral Foundation brags about a lot, which is

worthwhile. And it would not be hard to, as a group or whatever, put together six parameters that we're going to measure for diabetics.

It's the leading cause of heart disease, stroke, amputations, neuropathies, blindness, neuronopathy, and progression to dialysis. It's pretty big. And state these are six parameters that the State is going to measure, or I don't know. Premera has lots of data on this that my partners have refused to look at because we don't want to accept that you're watching us that closely. But that's an easy target. It's well-defined. There will be debate. Does tight glycemic control matter? Is there evidence for that? I think that's debate, but you could have a fairly simple, you know, trial project and just look. Can we do it? Can we do a better job than the national average as a state? It's a small population.

CHAIR HURLBURT: Paul?

COMMISSIONER FRIEDRICHS: And I would say that, you know, we are doing that. When you mentioned your 10,000 lives that you cover, just on the Air Force and Army side, we cover 39,000 lives -- excuse me -- 43,000 lives here in the Anchorage Bowl and we track, actually, more than six diabetic measures.

There's something called HEDIS. And for those of you who may not be familiar with it, there's a series of different

organizations that have come up with these measures over time, again, trying to use evidence to say that, in general if you can get the majority of your patients to do X, then their overall health will be improved. And so for diabetes, there are a number of measures like this that have already been identified and we track all of that for our patients, and those are things that are done both in the VA for their 17,000 or so enrolled lives and on the DOD for our 43,000 lives. So that is being done today.

And again reimbursements to the physicians from the VA system link to how well you accomplish those things. If that is where we want to go for the State, those measures are out there. We don't have to create pilots. The data is out there. And in fact, some states have done that. New York and others have begun to publish report cards that say here's how Dr. Friedrichs does. If you're a patient of Dr. Friedrichs, you're readmission rate after he operates on you is about 5%. You can compare him to Dr. Smith and Dr. Jones.

CHAIR HURLBURT: Most state Medicaid programs do use HEDIS, and I agree that Noah said that you can quibble over some of them. But basically, they're a national -- it's Health Employer Data Information Set. They are prevention type parameters that are well-accepted and widely used nationally for diabetes. There is the hemoglobin A1C. There is the, do you have your (indiscernible - background noise)

looked at every year? Do you have your feet looked at? Do you have other things done? What's your immunization rate at various ages, like two-year olds and other ages there? Are you checking your blood pressure on your patients? And for those who are hypertensive, what are you doing?

There's a whole list of things, and I agree you can probably quibble over some of them, but this is what used nationally. We really are an outlier in Alaska that we do not use that in our Medicaid program because most places do and many commercial payers do as well. So that is something that's established. I think you know, to have you all using it is -- to me, it's unarguably. That's the right thing to do, and we should foster the wider use of that.

As far as let me just respond to your other question. I think that this is the Commission now, and the Commission now should determine what we're going to do. We have five of our 11 members -- outside of the Representative of the House and Senate and the insurance office -- are new. So five out of the 11 are new, so it is a new Commission. I think the reality is that, to a significant extent, we do need to take what was done and build it, just from the logistics of it. It would be -- a lot of work did go into putting it together, and Deb's phenomenal but she is one person. So I think we want -- before we wholesale discard what was done -- but I think it's totally appropriate to look at it and say we do have a new

Commission. We do have some new perspectives and some new expertise, and do we want to make a bit of a mid-course on that? So I would kind of urge against the wholesale throwing out, but making modifications and changes in direction, I think, probably was a part of the intent of the Legislature in expanding and bringing new people on to the Commission here.

COMMISSIONER ERICKSON: Excuse me. Could you please mention on the phone that we're not able to mute them? And folks on the phone need to mute their phones because we're picking up their noise.

CHAIR HURLBURT: Yeah. Folks who are on the phone, if you could keep your phone muted, it would help. Every now and then, we're getting some background noise that makes it a little hard to hear and we can't mute you. So if you're on the phone if you could mute it, we'd appreciate it. Thanks. Jeff?

COMMISSIONER DAVIS: Thank you, Dr. Hurlburt. Just two minor points. One, we have 140,000 people total. I was just referring to 10,000 individual lives, people buying their coverage individually. And in fact, we do track that data. We have it available. It's in the claims data set. And in Washington where physicians have been more open to it, we have a very robust program of sharing routinely that data, particularly around diabetes but other majors as well that are well-established. And you know, that's something that could

easily be expanded.

CHAIR HURLBURT: In Washington State where the State contracted on the Medicaid patients, we had about half of the business, but then there was Community Health Plan, Group Health, Regents had a little bit. But basically they had a pool of $2.0 million a year that they awarded depending on how the health plan did with its enrollees, a combination of both absolute results and relative improvement over past results. So they had gone to try to incentivize better compliance with the use of HEDIS results. Dave, do you have something?

COMMISSIONER MORGAN: I usually -- I guess if it's like they said in Chinatown, if you hang around long enough, you start getting on boards or groups, you know, and stuff. It just seems like, on several occasions in the last year or so, whether it's EPSTAT, Early Periodic, or when we're forming a group to work on it statewide, the first thing that comes up is, well, what are we going to use as benchmarks? What are we going to use as standards?

Now I have in front of me out of *Financial Administrative Health Care* at least five articles talking about HEDIS, talking about benchmarking, talking about Accountable Care Organizations and Medicare share savings program, and it just seems just the thrust of the industry. And if we're going to make any headway on improving quality and getting these costs under control, we're just going to have to bite the bullet

here and go with a system of (indiscernible - recording interference). It's on. I don't know why it's not.

Anyway I'm not supposed to do this, but I'm going to do it anyway since this has come up. I belong to an organization that's been using HEDIS measures. We have about between 90 and 100 of them. We track it. We track it by physician of our empaneled patients, and it does what your system does for certain modalities. We need to do this and we track that, and the physician teams, the primary care teams that have behavioralists and the whole team there, nutritionists, the whole gambit, to improve quality, improve the health, and bring down how much is being utilized. And I think in our recommendations that I don't know -- in my own mind, I can't think of another way to approach this, unless you're going to get in draconian type decisions, and I don't think anybody really wants us to do that, I hope. So that's my two cents on this one.

CHAIR HURLBURT: Val, did you have a comment?

COMMISSIONER DAVIDSON: Well I guess I just had a question about this part of the agenda because, I think, our next conversation is going to be about where do we want to go from here and what our recommendations are, and I think we want to do that collectively as a group and not in isolation of one particular topic that happened to be on the agenda. So I guess at this point, the conversations about recommendations

are really helpful and they're interesting, but at the same time, I want to make sure that we don't do what sometimes happens in meetings where the idea that's being presented gets focused because it's the idea that's being presented in absence of a broader discussion about what it is that we're really asked to do, what we've been tasked to do by legislation, and in absence of a full complement of a discussion. So I assumed this part of the agenda was specific questions about evidence-based medicine, et cetera and not necessarily jumping into that's a great idea and here's how we should implement it as a part of our health plan. I think those are two separate discussions, even if they happen to be right. Otherwise, I'll start paying a lot more attention to agenda items from now on and advocating for items to be on the agenda.

CHAIR HURLBURT: Yeah, thank you. And I think we probably should consider this discussion related to evidence-based medicine, and you're right. The next session is the broader discussion of what are we doing. Representative Keller?

COMMISSIONER KELLER: Well on the same topic, I'd like to sure speak in support of your question that you asked, whether or not this should be a recommendation we make or not. And we, obviously as a group, have a lot of work to do on this recommendation. I mean, what are recommending? If we

recommend the increased use of EBMCER, then do we have a means of measure whether that's going to do any good, you know. And you know, we've been talking about following the money. You know, I was thinking about, are there workforce shortages in this area, like the statisticians? I mean, I'm not aware. I'm not real clear on the resources, like the *Hayes Directory* that you mentioned. Is that readily available? Is that online? But the only point in the overall picture that I'm trying to make is that -- or comment I'm trying to make is I really support that we focus on this.

Since the first time I heard of evidence-based medicine, I have been trying to figure what could be done legislatively to incentivize the use of it. I'm drawing blanks, and I'm listening carefully, you know, hoping that some kind of a direction would come out of this. And I think that's our job as the Health Commission to look for those specific directions we can move.

CHAIR HURLBURT: To answer the questions, yes, there are the resources, such as Hayes. They're available by subscription and Cochrane. The facility that the Blue Cross and Kaiser operates, Blue Shield in Chicago, some of that is publicly available and some of that, as I understand it, is available just to their constituent groups there. But there are a number of sources. As a major payer in the State, as an enlightened payer with the number of enrollees that we have,

the State could have some expertise in this but not enough to invent the wheel, but at least a person to coordinate that and pull in these resources and then have a larger group, including physicians, making the decisions. But I think that there is an opportunity for where the State pays, like for Medicaid, or for state employees as a payer to foster this but to do it, as I say, collaboratively with a group of people, but it probably does take a person to coordinate all that. Noah?

COMMISSIONER LAUFER: The adoption of evidence-based medicine is not going to be new news to any doctor. It will sound, you know, vague and like, wow, that's the first the Commission heard about that? You know, they're 30 years behind. But that's why I particularly said diabetes because it is, like I said, low-hanging fruit. The organizations that are primarily public health organizations are very, very good at it. Because it's an organization, it's hierarchical. Because the computer screen says even though the patient is here for, you know, their prosthesis, they haven't had an A1C.

UNIDENTIFIED COMMISSIONER: Impotence.

COMMISSIONER LAUFER: Impotence. Sorry. Well that is more directly related to their diabetes. But anyway the reason I think diabetes is good is, I think, we know and a lot of docs in private practice know that we're good at the acute visit. That's why people come to see us. They don't really

want to talk about their diabetes. They want to talk about their ingrown toenail, and they want that addressed now. And we know we're bad at it in comparison to the public health oriented docs. We're more individually oriented, and I think there is a great strength to that, but this is our weakness and we know it as our weakness. And it's low-hanging fruit, and it's not very controversial that you should be doing these things. And we all anticipate it happening. So it makes sense to have some very well-defined parameters -- we already know it's evidence-based medicine -- and just say this is something we're going to be looking at. It's allowing us to move from the individual based health a little bit more into the public based health and that's the direction we need to go if we want to have evidence-based, higher quality, and cheaper care. So it's sort of the ideal specific challenge, and it would have a huge impact. So while it is off track, it's the best use of it. I think telling -- you know, I don't want to make the decisions about HUMIRA and Enbrel, and you know, I'm lucky I defer that to a specialist. You know, those things are already debated because, you know, there's a bill for $200,000. But this is a simple way to get, you know, the herd of cats that we are sort of on track in the same direction. Sorry. I'll stop.

CHAIR HURLBURT: Paul?

COMMISSIONER FRIEDRICHS: Thanks. I think sort of

getting to your point again, we have the benefit of being able to look at what other states have done from a legislative standpoint. And again I'm not espousing a solution. I'm just offering the observation that, whether it's in what Noah was describing as a public health or publicly funded health care system, like the VA or DOD, or states, like New York or California or others, there is a pretty good track record now to say these are things that change patterns of practice.

It turns out most physicians have an ego. Probably news some folks, but they don't like to be called out to say, wow, Dr. Friedrichs, you've got a 20% readmission rate and everybody else in the city has got a 5% readmission rate. Either you've got really sick patients or really bad surgery, you know, one of the two and that turns out to be effective. Not terribly expensive to do to put those report cards out there on the Web. Some states have done it at the hospital level or at the health plan's level. Others have taken it down and many of them now are going to the individual physician level as a means of educating the consumer, and this gets back again to what are our goals. If this is partly to get the consumer involved in health care decision making, I can go and look and see which car in consumer reports has the best track record for having to go to the shop and which shop is going to have the highest cost for repairing that car, but you can't find out much about doctors or hospitals. Medicare

and Medicaid are starting to publish some of that -- or Medicare is starting to publish some of that data on hospitals at the national level. We could certainly do that, as other states have done, at the individual level here.

CHAIR HURLBURT: Yes, please?

COMMISSIONER KELLER: I just want to point out that probably Legislators have an ego too, have an ego problem or whatever, but this is really helpful this level. Like this presentation is really helpful to me. And unfortunately what happens is a lot of our policies and incentives get set by people that do not understand, you know, even this. I mean, I confess; this is -- I learned more today than I knew, you know, and I'm impressed, you know. So I mean, it isn't just consumer education. I think -- you know and I know this gets into maybe the next session a little bit, but it's also, you know, education of the policymakers that end up making the policies. Thanks.

CHAIR HURLBURT: I think the transparency that Paul was talking about in terms of outcomes and in terms of costs is one of the things that was on the list I had there yesterday that we can get into. There was an interesting report just last week where Oregon has tried to have their hospital charges, fee schedules be transparent for three years now, and their conclusion wasn't helping. They had five different diagnoses in the Portland area that they publicized the

highest cost and the lowest cost for the same procedure. There was, like, childbirth. There was, like, cardiac surgery. And there was a difference of 100% between -- without differences in quality outcomes. And probably that relates to the socialist principle that, until we run out of somebody else's money, we're not going to do much. But it was interesting and a little discouraging to read that because we really have been hoping that transparency -- but it goes back to, like, the early Blues days 80 years ago now where, yeah, there was community rating and community coverage, but everybody had more skin in the game.

COMMISSIONER LAUFER: It's also apples and oranges. When I was in medical school in Philadelphia, the *Inquirer* published this article on the outcomes for CT surgeons. And the best CT surgeon statistically in the community was at my hospital, and he was approaching 80. He was, you know, a delightful and wise guy, but he hadn't done any significant CT surgery in a long time. He did primaries on health young people who had valve replacements, and people who are healthy and young when they get surgery do well. And the best CT surgeons had bad numbers because they were operating on people who were desperately ill and going to die otherwise, and the result of this is people get Medivac'd in. It's the East Coast. They're very much into, you know, I need to have the absolute best. He would kind of teeter by with someone

holding his arm, and he would look and say I'm sorry; I can't do your surgery. They're in utter despair. They're going to have to settle for the third or fourth best guy. The overall effect was it was a total disservice.

Diabetes is the strength of these public health oriented clinics. I'm -- this is our Achilles heel. I don't know that it would be great to advertise that from my point of view because it doesn't highlight the tremendous weaknesses of public health either, but it is the place that we could improve the most.

CHAIR HURLBURT: Yeah, and I think we've seen other examples that, in the public sector type programs, like Paul has and was describing, the use of beta blockers post-MI was a hit of the private sector. Now if you have an MI, your chances of getting a beta blocker are pretty good anywhere, but there was a long time when it was, like, 85%/90%, say at Elmendorf, and a lot lower elsewhere. So I think we've got a good precedent for what you suggest there. Any other comments before we quit? We're right at 10 o'clock, and I think we're ready for a break. Thank you, all.

10:00:37

(Off record)

(On record)

10:22:35

CHAIR HURLBURT: We're back on record and next is the

Goals for 2010 Commission Report and Looking Ahead to 2011 Work. I want to remind us partly to set it before us, partly to verify that with our new expanded group that we're in concurrence that we're going the right way. I actually didn't hear anything in our earlier conversation that was -- that I felt was divergent, at least as I understood the direction that we've been going, but we want to review that and give everybody a chance to check in on that. So Deb, I'll turn it over to you.

COMMISSIONER ERICKSON: Thank you. Just being real task-oriented, what I wanted to get out of this session for the next couple of hours is a good sense of what we need to do to focus on over the next couple months to get our 2010 report completed, but also looking forward to the next year, what we need to do to start lining up consultants for additional learning that the Commission might need to do and additional information that might need to be gathered, study around both the current system and ideas for different strategies, like the ones we were just talking about so we have a sense of what we can use our consulting dollars for and how we're going to set the agenda for the next few meetings. So that's what I'm hoping to get in terms of direction from the conversation we're going to have over the next couple of hours.

I was talking to a friend last night after the meeting yesterday, and he was asking how the meeting went. I said it

was a great meeting, great group. I said, at the end of the day, I felt like I had a much better sense of where the group was coming from. It was just kind of a blank slate after ten months of no meetings and then reconvening with five new members, but I felt as though I had a much fuzzier sense of where we're headed than I did coming into the meeting. And so this conversation this morning, at least the one track we went off on, was perfect in terms of kind of validating my sense at the end of the day yesterday and setting us up for this conversation.

So we're actually -- I just pulled in a number of slides to the presentation that you have behind tab seven and that's available on the Internet and in hard copy in the back of the room. Because I think, again based on the conversation, we need to take a few steps back and check in on what we've set up for planning framework for the overall work of the group and what we've defined as the vision. And when I say we, the former initial Health Commission. What we've identified as our kind of main four-part strategy for moving forward. So I'm going to take a little bit of time to step back and do that. So you don't have the -- you do have these slides in the presentation that I gave yesterday morning. I've just pulled them into the new presentation for today.

So starting with the Commission's strategic plan and the five-year planning framework that's laid out in six bullet

points, starting with defining the vision, accurately describing the current system, building the foundation for the improved system, designing the transformation elements that will help us move in the direction of achieving the vision, and then how we measure progress and engage the public and stakeholders along the way.

Just in terms of a planning process and the elements for a planning process, does that six-point planning framework still make sense to this group or does it make sense to our new group?

(Pause)

CHAIR HURLBURT: Is it okay to assume that silence means agreement? Okay.

COMMISSIONER ERICKSON: No, they're looking. I'm giving.....

CHAIR HURLBURT: They're looking.

COMMISSIONER ERICKSON: I'm going to give them some time to think. I see some nodding heads, and I see some squinting. Squinting and nodding. Does anybody have questions about what any of those six elements mean? Val and then Paul?

COMMISSIONER DAVIDSON: I do. I guess I keep going back to the point I brought up yesterday and again today of specifically what we are asked to do. We're asked to do two things. One is to develop a comprehensive statewide health policy, and the second is to develop a strategy for improving

the health of all residents of the State. And then there are additional elements under that. And so I'm wondering how those specific deliverables that are required by law fit into that framework or how that framework fits into getting us where we need to be, and they're very specific. It's everything from personal responsibility, reducing health care costs, eliminating known health risks, including sanitation, safe water, and waste water systems, developing a sustainable health care workforce, improving access to quality of care, and increasing the number of insurance options.

COMMISSIONER ERICKSON: I see this planning framework as kind of providing the process pieces for how we're going to achieve -- what's going to get us towards defining the statewide health care policy, and that the second part of our duty description -- if folks want to be looking at the duties, there are a couple of places you could look. You -- the Commission members have a copy of SB172. That's our law to which Val is referring. You have it behind tab two in your notebooks, and it's on page five. Or you can refer back to the presentation that I made yesterday, and there was a slide in that presentation that kind of captured those two main bullets without all of the details below of the different strategies we should consider. But then Val, again the five-year planning framework is the process to help us achieve that policy, to get the point where we've defined the policy. And

the second part, the strategies for improving the health of all residents, that would come in as the different strategies or elements that we might define as part of the planning framework. Does that help? It's more kind of the process piece to get us to these deliverables. Paul was next and then Dave.

COMMISSIONER FRIEDRICHS: I just offer the thought, having just come off of the federal task force looking at some of the same questions, five years is a very, very brief window to look at from the standpoint of health care infrastructure. In a state that is growing its infrastructure and has had incredible growth over the last 30 years, my suggestion and the approach that we took was really to look farther out as well. We need to put some markers in the sand that, if the population continues to grow or if we're going to achieve certain goals, some of these are going to take us well beyond five years to achieve.

COMMISSIONER ERICKSON: I'm sorry. The five-year planning framework isn't meant to define the timeframe for which we are planning but over which we're planning, that this plan will be developed and evolve over a five-year period, not looking at defining outcomes and objectives for the health care system that we'll achieve within five years. Does that make sense?

COMMISSIONER FRIEDRICHS: I guess I'm not sure. So we're

going to take five years to develop this plan?

COMMISSIONER ERICKSON: Well if that's -- potentially. I mean, the idea is that it will evolve over time, that we will, in the first year -- and that's why there are kind of a couple of other elements for the overall strategic planning process that each year we're identifying. We're not going to get to the point where we can identify every strategy that's going to work for moving us towards achieving the vision in just one year, and that we'll continue building on it while still revisiting, each year, how the recommendations we made in the past are doing. Can we evaluate those? If there has been enough time and implementation, can we identify whether they've been successful or not or whether we need to tweak them and make some improvements and still keep moving forward with identifying additional strategies. So it's -- I'm picturing more of a rolling process or an evolution over time. We're not going to meet for a few months, come up with a plan, set it in place, and walk away.

UNIDENTIFIED COMMISSIONER: (Indiscernible - away from mic)

COMMISSIONER ERICKSON: What's that?

UNIDENTIFIED COMMISSIONER: Spiral development.

COMMISSIONER ERICKSON: Spiral development. I hadn't heard that before, but sure. Continuous quality improvement. Dave?

COMMISSIONER MORGAN: Wow, it sounds like Baldridge almost.

COMMISSIONER ERICKSON: Sorry.

COMMISSIONER MORGAN: I was going to make two comments. Now I only have to make one, I guess. In looking at our duties, it also goes into some other really broad areas, you know, from cost saving measures to health information technology, management efficiencies. But I wonder as the -- and I don't think it's been mentioned, but we all know, most of us were there, there was a Medicaid task force. It was mentioned once, I guess. A Medicaid task force is doing some things, looking at some things, coming up with some ideas. They have a very short reporting zone. I think they're going to meet four or five times. Wes is on it and Bill Strewer and some other individuals. As they -- you know, that's moving along. We have a bunch of federal stuff going on.

We have changing economics changing everything right now, and it's almost, as we're going through this process, the benchmark or the light buoy that we're using to maneuver through this is constantly moving, and it seems to be, right now, more forces operating around us, moving all of these issues around in the entire health care delivery system. I guess I don't want to sound weepy on this one, but it just sounds like circumstances may outstrip our five-year planning framework, that we -- I don't think we -- I don't think

anybody expects the Commission to do anything in the next three months, but I don't know if five years of reporting is acceptable to the public or to the Legislature. I think maybe interim reports and updating them might be a better way to meet that, plus, as my colleague said, five years in changing -- it's like changing the direction of an aircraft carrier. It takes about a mile-and-a-half to change, even by a few degrees, the direction of an aircraft carrier, and it is a $7.0 billion boat that's moving through there. So I just thought I would mention that so that you could think about it this weekend and ponder it, but that's just what's going through my mind. All the stuff around us happening, all of -- even a Medicaid task force being formed, plus all this stuff going on, maybe some of our ideas on planning framework time limits we may have to adjust and even the duration of the plan, or intermediate planning might have to fall in.

COMMISSIONER ERICKSON: Let me clarify some more. We do still have an annual report due every January 15th every year. The five-year window was actually set at the very, very beginning of our process at the beginning of 2009 because we were anticipating, at that point, that there was going to be a law passed establishing the Commission in statute that winter, a year before it actually did pass, and that it would sunset after five years. So the idea was to put in place a planning framework, a planning process that would evolve over a five-

year period with annual reports coming out and that we weren't waiting or taking five years to produce a report and a plan, that we were coming up with recommendations each year, setting an evaluation process in place so we could check back on that, and that there would be some work, such as there was in the end with implementing some of the recommendations that come out each year, not waiting until the end to move forward. Does that help?

COMMISSIONER MORGAN: Well yeah. I understood that we weren't waiting to the end. It just seems like we've got a lot of stuff happening, even on the one-year one. You've got a real short window on the first one, but it seems like the landscape and the forces around us are just hitting us from a lot of different sides and moving a lot of the buoys around.

COMMISSIONER ERICKSON: Right.

COMMISSIONER MORGAN: And I guess it's more of a lament. I don't know what we can do about it but just manage our way through it, but I think we're.....

COMMISSIONER ERICKSON: I think it's part of describing the current system. I mean, we're not going to go into detail and analyze because we just don't have the capacity all of these other forces, but just recognizing that they're there is part of understanding the current system as we're trying to come up with and identify the strategies to help make improvements.

COMMISSIONER MORGAN: We're all going to have to -- I think we're all going to have to understand that we're all -- as we say in the South, everyone's going to have to give a little to get a little, kind of. We're going to have to work a lot of these through because there is a lot of counter-veiling forces in this from reimbursement all the way to private physicians. I won't list them all. It's just that we're all going to have to give some in order to get the work done with some recommendations through the process.

COMMISSIONER ERICKSON: Did you have something more, Ward?

CHAIR HURLBURT: Yeah. I think and I agree with Paul that we've got a multi-decade issue that we're talking about, but to some extent, long range planning -- and I include five years in that -- is like a weather forecast. The meteorologist says it's pretty for this weekend, but the ten-day forecast or the 30-day forecast you might as well have Divine inspiration. It's kind of a guess. And I think when I've had to do long range planning, I've often done that in terms of, well, that's what you do to keep your boss happy because that's what they want. But as long as you have some clarity around your vision, it is going to change.

So I'm basically agreeing, I think Dave, with what you said. And I think that, you know, Representative Keller would probably reaffirm, I would guess, that the Legislature and the

Governor's office really are interested in what can we do now within the context of the overall picture, recognizing that some things are going to take a mile-and-a-half to turn the battleship, but what can we do now? And I think that in setting up the Medicaid task force that Bill Hogan is chairing and Senator Olson is on that also that that by design is a six-month process because the legislative session is going to end and the desire on the part of both the Administration and the Legislature is to get some things now.

So you know I think if we keep what we do in terms of the overall vision of where we want to go but do try to target what do we want to recommend in January to the Legislature that has a session coming up, to the Governor's office who will be developing policies there, and we'll have a, you know, four-year Administration ahead of our Governor at that time and politics will be out of the way for a while a little bit -- and so I think it's important for us to recognize what can we say, what can we do now, what changes should we start to make?

COMMISSIONER ERICKSON: Wes?

COMMISSIONER KELLER: If I could, one of the most risky things in the world is to speak for the Legislature. I don't mean to be doing that. But from my perspective -- and I think it is right on -- is that the five-year sunset is a signal, you know, and the signal is what we want here is some low-

hanging fruit addressed in a way that dramatically affects the fiscal picture. That's why it's based on cost because we know, you know, largely, I mean, more and more of us are becoming aware of the crisis, the pending crisis that's there, you know, with the rising Medicaid and health care costs, and we just realized we have to address it. You know if I was to speak for the Legislature, I would say the reason the five-year thing is there is not at all to limit the planning and the scope. In fact, I think there will be a whole lot more excitement about keeping the Commission going if it is long term, of course, and the bottom line is, you know, that's just the way the Legislature operates because we're the ones with the checkbook. So you know, that's -- you know, what we're trying to do is incentivize a product here that can actually affect a policy that we make and also a policy that Health and Social Services employs. So for what it's worth.

COMMISSIONER ERICKSON: Noah?

COMMISSIONER LAUFER: What would be a significant enough change or accomplishment to impress you guys?

COMMISSIONER KELLER: Well you know, what impresses me -- because again I can get in real trouble here if I speak for some of my peers, but what impresses me is just the breath of fresh air looking at new approaches and getting the -- you know, educating everybody out there what the issue is, like the evidence-based management presentation we just had. I

think that would be -- you know largely, the Legislature, if they were able to sit in and listen to this thing, they would be very impressed, you know, and now how in the world do we get from here to there, you know. And like Paul pointed out, the pay structure is really, you know, the elephant in the room here. How do we get from here to there? How do we change that so that we're paying for what the results are, rather than paying for, you know, services? And how to get there is the problem, coming up with where the rubber hits the road. What can we do legislatively, regulation-wise in the Department or whatever to get there, you know, to change the incentives?

COMMISSIONER FRIEDRICHS: And thank you, sir, for clarifying that, and I guess that's what I was struggling with as I was listening to your presentation. If we are constrained that -- you know, the goal is we just need to save money. This is costing too much. We need to save money. Again that drives the discussion in one direction. If it is we actually want to save money but we also would like to come out of this with a good health care system where, you know, people actually get good quality health care, they live longer, they're contributing taxpayers for longer, that's a very different discussion than saving money. If it's that we want to attract people to come live in Alaska because they've got the best health care, it's an innovative place, this is

kind of the cutting edge -- and oh by the way with global warming, it's actually the most comfortable place in the country, you know, that's a third discussion to have and that's what I'm -- that's the part that, you know, I think you said was sort of option two that we're leaning towards.

For me as a surgeon who kind of says, find problem, cut it out, move onto next problem, I'm still trying to understand exactly what the problem is from the Legislature's standpoint. We see it in what is written in here, but this is pretty broad.

COMMISSIONER KELLER: Of course. And again this is why I get in trouble speaking for the whole Legislature, but of course, that is, you know, an integral part of it, is a health plan and system for the state of Alaska, that we have the most healthy, you know, happy people in the United States of America. I mean of course, that impresses legislators very much, but the reality of it is there is X amount of dollars. We don't have a printing press, and you know, costs are driving up. So the driver here is a little bit the panic of what we're going to do, but of course I mean you know, we want the best, you know, plan. And so to me, you can't really separate them. They're just -- the quality and cost are arm-and-arm, as far as in the context of what impresses us, you know.

COMMISSIONER ERICKSON: I think this might be a good

segue actually to the next part of our discussion here, but I want to just check in on the construct for our planning process. So as I was explaining it, I didn't want to make it sound as though I was defending it. I just wanted to make sure it was clear. If there is some aspect of this or the overall framework you just don't like, we can throw it out and start over again if you have suggestions for tweaking it, if you like it. I just want to get a sense from the group. Does anybody dislike it? I mean, now I'm seeing nodding heads and thumbs up. Does anybody dislike, not understand, or want to make some change to just our planning construct?

So then moving on assuming we're following this framework, at the end of the first year, the Commission had developed the vision and had checked that one off, but we're going to take a minute to step back and look at that again, just in light of our conversation actually yesterday and today.

So the vision -- and also linking it back to our law too, our statute, our enabling statute, there are the two aspects of developing the policy, but the strategy, part two -- the statewide health plan is to contain a strategy for improving the health of all residents that encourages personal responsibility and reduces health care costs. So I think its capturing eliminates known health risks, develops a sustainable health care workforce, improves access to quality

care, and increases the number of insurance options for health care. So that's the range of the scope of our duties is defined in our enabling statute. So the vision that the initial Commission defined was that we would have a health care system in the future -- but we didn't identify how far out in the future we were imagining we would be at this point -- that produces improved health status, provides value for Alaskans' health care dollars, that consumers and providers are both satisfied with the system, and that it's sustainable.

So those were the four elements of the vision that we had for the future. So is that something that our new group wants to take a little time to revisit? Is the picture of the future, are there important elements in that picture of our perfect health care system that are missing, or does that matter? Does the new group not feel enough ownership in this? Should we throw it out and start over so everybody feels bought in? Does anybody have questions about any of the elements?

COMMISSIONER MORGAN: I think they're broad enough. I think we -- I've not heard anyone say, boy, I have a problem with sustainability as a value. So I don't think anybody wants to start over. I think we want to kind of take what's been built and move on to the next steps and look at the issues and develop some recommendations. So I mean, it seems okay to me as a new member.

COMMISSIONER ERICKSON: Other thoughts, not just from new members? Former members, if you think we left something out or.....

COMMISSIONER HALL: Silence is deadly.

COMMISSIONER ERICKSON: That's why I'm trying to read faces.

COMMISSIONER HALL: I know you are, and I've been there so I thought I would at least say something. I think those of us who were on the Commission last year worked -- and you mentioned earlier today the give and take and having to reach agreement, and we probably spent more time than you would imagine coming up with this vision statement, and every word in there probably represents a significant amount of time to come up with. I would like to think we -- and if we're moving ahead, if somebody has a tweak they wanted to make, but I think our goal when we did some of this last year was that we didn't have to reinvent the wheel every year, that we could, you know, move forward. And it is a new group with new members, and I think we're all certainly receptive to changes, but if we're going to start, like, all over again, we'll never get anything in five years or ten or whatever. So I like the vision. I was part of making the vision. I'm receptive to tweaking it, but I really strongly encourage us not to reinvent the wheel.

COMMISSIONER ERICKSON: Yes, Emily? And then Pat.

COMMISSIONER ENNIS: I believe the vision is clearly stated. It's ambitious, but I think that's what we want and I find it totally fine. So as a new member, I'm all for it.

COMMISSIONER BRANCO: I agree with Emily.

COMMISSIONER ERICKSON: Thank you, Pat. We can take a little bit of time for group process.

COMMISSIONER LAUFER: I think the only thorny one there is number three, improved quality, because how is that measured?

COMMISSIONER ERICKSON: Looking at the -- look at the reform goals, right.

COMMISSIONER LAUFER: And this kind of comes to the crux of the whole issue which is a more generous view of, you know, what is life about. It might be far better as far as quality of life to have home health care at the end of life for Alaskans than $200,000 for an extra 12 days' of life. And you know, measuring quality is very, very difficult. Anyway, that's the only one that I see as really ambiguous.

COMMISSIONER ERICKSON: And looking at those four reform goals then of increased access, controlled costs, improved quality and prevention based, we did not get far enough along in the process to either set targets for those or identify the indicators by which we would measure if we were accomplishing those goals, and that was kind of a next step. It was actually something if we had time that we were going to talk

about this morning. And if we don't talk about that, we can at least maybe talk a little bit about process for moving forward, if you want me to just some more work on it, if you want me to hire a consultant, if you want to take it home and do homework with it, but we'll talk about in a little bit. But I think that, hopefully, will get at your point, Noah. Yes, Val?

COMMISSIONER DAVIDSON: So how about instead of improved -- I'm trying to provide an edit that might make the -- might improve it. So how about improved health status or improved health outcomes?

COMMISSIONER ERICKSON: That's a different goal than what was intended in this goal. It was intended to be a focus on quality and safety of health care. Yes, Noah?

COMMISSIONER LAUFER: What if the outcome is death? You know, it's obvious. But we don't talk about this, but we all die. And there is such a thing, actually, as a good death, and there is such a thing as a horrible death. And the outcome is terrible, you know; 100% of your hospice patients died. Geez, what are you guys doing?

COMMISSIONER DAVIDSON: So I guess the point I'm trying to get to is you don't like improved quality. So what would you offer as an edit to address your concern?

COMMISSIONER LAUFER: I think it's hard to define that. How do measure this? (Indiscernible - away from mic)

COMMISSIONER ERICKSON: Yeah. Let's just finish the discussion on the vision and then we can focus on the goals. Were there any other? Colonel Friedrichs?

COMMISSIONER FRIEDRICHS: I think this is Jim Spiffy. Can we move on to the specifics?

COMMISSIONER KELLER: Can I make one comment?

COMMISSIONER ERICKSON: Yes.

COMMISSIONER KELLER: The improved quality, in my mind, ties with the satisfaction and that could tie with what we measure, you know, the provider-consumer satisfaction.

COMMISSIONER FRIEDRICHS: Yeah, and I think that will address many of the concerns that we've heard this morning. That's easy to say, but what does it mean?

COMMISSIONER ERICKSON: Go ahead.

UNIDENTIFIED COMMISSIONER: Turn on your mic.

COMMISSIONER FRIEDRICHS: What I just said was it's easy to say what does it mean, which is another way to say let's talk the specifics.

COMMISSIONER ERICKSON: Right. Moving on, do we need to revisit.....

COMMISSIONER DAVIDSON: So did we refine the goals?

COMMISSIONER ERICKSON: We did not; no. No, I think -- my sense is the group was fine with the goals, but they're basically saying the devil is in the details, I think, and we need to understand better. In terms of a general statement,

it's a good goal, but what's going to make it meaningful is what we're defining as improved quality and how we're going to measure it. Am I -- is everybody okay with that?

COMMISSIONER FRIEDRICHS: You're really smart and thoughtful about this, so if I miss something, please say so.

COMMISSIONER DAVIDSON: I just was -- I thought we were doing the vision first and then we were talking about the goals and then we were going to the values. So I just misunderstood the process. So if folks don't have a problem with the vision as stated, the reformed goals as stated, and the values as stated, then I think we can move on to the next slide. I just didn't hear that we were there yet. So that might just be my confusion.

COMMISSIONER ERICKSON: Is everybody happy with our vision, goals, and values for now as stated? Got it. You know, we had defined this strategy. I don't know if we should take time to revisit this right now. Identifying the three kind of foundation pieces for building an improved system, having a strong workforce, health information technology available, and strong statewide leadership for helping with the policy decisions that need to be made to support improvement in the system, and that it's all leading to enhanced consumer's role in health care, both through innovative primary care and incentivizing healthy lifestyles.

Any questions from our new members about this system

transformation, a general strategy? Yes?

COMMISSIONER FRIEDRICHS: And so we don't exclude innovative specialty care though. We only want to be innovative on the primary care side, just so I.....

COMMISSIONER ERICKSON: This.....

COMMISSIONER FRIEDRICHS: Because innovative specialty care would be, hopefully, less expensive and higher quality than what we're doing today. I mean, that would be actually fairly innovative on the specialty side, but if that's not what we want, then we shouldn't head in that direction.

COMMISSIONER ERICKSON: Dr. Hurlburt?

CHAIR HURLBURT: I don't think the intent was to exclude that, but the intent was to include the current buzz word about the good things behind the medical home, of this longitudinal relationship with primary care, that we saw that as maybe being -- if you have to prioritize, maybe being more important than the innovative specialty care or non-primary care specialty care but not to exclude that. That would be my take on it.

COMMISSIONER FRIEDRICHS: Well I mean, I can speak for many of my colleagues. We're good at not innovating. I mean, we're comfortable with the status quo, if that's what we're going to recommend.

COMMISSIONER ERICKSON: Well these are two elements specifically meant to support the consumer's role in health.

That was how the conversation evolved that actually started the very first morning of the very first day of the very first meeting of this group with that being a focus we want to enhance the consumer's role in health and health care. And over the course of learning and discussions over a few meetings, the importance of developing these new models of care in primary care was seen as the most critical piece, working on the medical system side, that would support improved consumer engagement in their medical care and that then we needed to also look on a policy side at what we could do to incentivize folks to live healthier lifestyles. So it was those two pieces coming up to support the consumer's role in health, and I don't think it intended to exclude specialty care. It was just part of the strategies being a little more focused and understanding that we couldn't address the world, but if we need to pull in some of these other issues and maybe they'll come in through the statewide leadership triangle. Does that -- am I accurately reflecting how this conversation evolved over the course of a year? I'm asking the former Commission members.

UNIDENTIFIED COMMISSIONER: That's what I remember.

COMMISSIONER ERICKSON: Wes and Wayne are nodding their heads.

COMMISSIONER CAMPBELL: Well and I think that this was intended for the policy makers in the Legislature and the

Governor's office, and we want to encourage and have the incentives to, if it takes funding, if it takes -- and re-ordering and re-prioritizing the payment mechanisms in getting this manpower into the State where it's needed. But I guess I just have to offer this up; I had forgotten how much fun a medical staff meeting could be.

COMMISSIONER ERICKSON: I'm enjoying it. Yes?

COMMISSIONER MORGAN: I'd like to remind everyone we all have to give a little through this.

COMMISSIONER ERICKSON: Jeff first and then Val.

COMMISSIONER DAVIS: Thanks. I know, Colonel Friedrichs, that was a little bit tongue-in-cheek, but on the other hand, I think you have really hit an important point in that -- and not because it was driven by the agenda and it is top of mind, but there is this whole other aspect of improving -- both you and Bruce were right. It is cost, cost, cost, and it is quality, quality, quality. And I'm not sure that what we have in the triangles captures that. There seems to be a missing piece to it. I mean, there is nothing in there that shouldn't be, but there's this whole other element that we've been talking about today that somehow we not incorporate it strongly enough, I believe. Thank you.

COMMISSIONER ERICKSON: That's helpful. I don't think we need to answer the question today if we have a missing piece, what that piece is, but it's good to identify that this is

something that we will keep working on as part of our evolving plan. Val?

COMMISSIONER DAVIDSON: So I'm just trying to propose some solutions to ideas and concerns that we've heard. So what if we said innovative health care and healthy lifestyles because it captures more than just primary care. It also captures some of the behavioral health elements. It captures specialty, et cetera. It's broad enough, and I think the point of this slide and this triangle is for it to be broad enough to capture sort of the vision and the strategy. But it changes things a little, and the question is, do we want to do that? And I guess -- I mean just in terms of going through these slides, I'm assuming that if I agree with something, I'm not going to say anything. If I disagree with something, I'm going to let folks know what it is and then perhaps even propose a solution that will address that concern. So just to recap what I think I heard was that folks thought that primary care was too specific and so perhaps it should be (indiscernible - simultaneous speaking).

COMMISSIONER ERICKSON: One person thought that primary was too specific.

COMMISSIONER DAVIDSON: I thought I heard two.

COMMISSIONER ERICKSON: Two, okay. And I think what we were -- we were at the point of accepting that and saying we are missing something, but I don't know if we need to fix that

right now, that we need to continue -- I mean, this was something that evolved -- this picture evolved over the course of a year. Well the four elements came out in our first meeting; that's right. But this group spent the whole first meeting doing nothing but talking, and we haven't had an opportunity to do that yet. So we're kind of having to regroup and reform and re-storm a little bit and that's okay, although it might feel painful to people.

COMMISSIONER DAVIDSON: So I'm sorry I keep coming back to process, but if we're not really going to change these, then I.....

COMMISSIONER ERICKSON: Well we're identifying whether they need to be changed or not and then we'll come up with a process for whether we need to change them. I'm a little concerned if we try to fix everything right now that we might identify needs to be fixed that we're not going to get through the next hour.

COMMISSIONER DAVIDSON: And I guess the only concern that I have is that we have a report that's due that needs to reflect what the -- I mean, this is pretty basic to our -- I mean, this is like the meat and potatoes or the caribou and the wild, you know, whatever to our discussion, and I think this is pretty critical to shape where it is that we want to go. And if we don't fix this and we continue on with writing the report and then we come back to say we're going to fix

this later, we've sort of missed the point because I thought I heard this is the basis of our strategy. And if the report is going to reflect the strategy but we've said that the strategy isn't really complete; we want to fix it later, when we will we really have that opportunity to do that?

I just remember I missed one meeting last year. It was the first meeting. It was in which all of these happened, and you know, I won't miss a meeting. I'll try not to miss again this year, but I'm just saying that, when these things move on, they sort of develop a life of their own, and we just need to be careful that what we do right now -- and if this is going to be the basis of our strategy, let's be honest about that because there won't necessarily be the opportunity to change that as we progress.

COMMISSIONER FRIEDRICHS: And Val, I very much appreciate those comments, and I agree with you. Having done this in a variety of forms and different times, there is no right way to do it, but I'm still trying to understand, as you are, the process that we're going through.

Going back to your point, sir, about it being both cost and quality but cost being a key attribute of that, innovation seems to be a necessary part of any solution set, I mean, doing things differently.

The medical home model is an absolutely splendid idea. That's why all of us, I think, in the public sector have

adopted it. We recognize that that is absolutely the right thing to do, and the evidence supports that, but there's a lot of innovation out there that's going to be required to both rein in costs and improve the quality of care. It's not exclusive to primary care. The mental health arena, particularly here in Alaska -- you know, I've got people stacked in the emergency room like cord wood waiting for beds because we don't really have a great mental health capacity here.

All of those are things in which innovative solutions are needed. And so I would offer from the standpoint of both identifying a problem and a solution that the consumer's role in health critical. I absolutely agree that. Everything that you have up here; all true. Innovation though cuts across many areas beyond just primary care and is another attribute that's going to be required in a solution set. So I would make it less specific and then move on.

COMMISSIONER ERICKSON: Just in -- when we were working on this piece, there were issues specific to primary care and I would be a little concerned if we just changed a word that we're throwing out the learning that went on and the interest in focusing on primary care that was developed. So that's why I'm pushing back a little bit on making what seems to be a simple change without thinking about that, but if the Commission -- if it's the will of the Commission to change

that and move on, we can do that, just recognizing that the group had been really intentional about the focus on primary care. I'm not arguing against not looking at innovation more broadly, not looking at specialty care, assuming that we can identify either focus time at the next meeting on reworking this picture and bringing those other pieces, or identify it as a missing piece in this first three month report and work on it next year. Yes, Noah?

COMMISSIONER LAUFER: Obviously I'm here because I feel strongly about primary care and I don't think it should be eliminated because, I think, it's a huge part of the eventual solution, but rather than eliminate it, why don't we add, you know, some other wording to include other places that we could see innovation? Would that be okay?

COMMISSIONER ERICKSON: Yes?

COMMISSIONER KELLER: If I could offer a suggestion for what it's worth, why don't we -- you know I mean, there's going to be things like this in the foundation of this Commission that need to be addressed so maybe we can take a future time and look at it like you would look at an amendment to anything, you know. In other words, propose it beforehand so we all have time to think about it and do a little bit of review. And rather than make any changes here on the fly, I can really sympathize with what Deb is saying because, you know, we don't all have perfect memories. So if we go back

and look at, you know, our discussions of what was around this, we might discover a whole different element. I'm sitting here wondering if it didn't have something to do with our identification of the fact that primary care is the cornerstone problem that we have to address, you know. So we may have been incorrectly -- I'm not arguing for or against what you are proposing. We may have been focusing on that as a challenge that we needed to address, but my real point is is process. If we're going to change this, I'd be more comfortable with we take a block of time at a future meeting and have time to look at it beforehand and you could defend any changes you propose and that kind of thing.

COMMISSIONER ERICKSON: Yeah. I think we're not fundamentally changing this picture at all by adding to it. So I don't think it's taking us off course to wait either. Wayne?

COMMISSIONER STEVENS: Well given the conversation just adding the word specialty in the white letters there, innovative primary and specialty care, and healthy lifestyles, does that not incorporate the discussion we've just had and then we can segue on to the next discussion? It addresses the concern because it doesn't diminish primary. So it would just read innovative primary and specialty care, and healthy lifestyles.

CHAIR HURLBURT: I think that nobody disagrees with the

opportunity for innovative specialty care, and clearly, that's very consistent with our mission. And this is just a diagram, but I think as far as developing and fleshing out what our recommendations are, my sense, going back to our earlier discussions and I think what Noah is saying -- bringing here, is we see that the increased focus on the, quote, good aspects of primary care the way it ought to be as being so fundamental, so much of a building block that, yes, that really has to be a priority. So I think that, to incorporate that, would show we're not forgetting it by saying specialty care, but I think as far as our thrust, as far as we can't do everything all at once and we can't have a five-year plan all at once, but we can do this much. We want to get some specific recommendations out. I think the primary care part, to me, was pretty foundational out of our discussions.

COMMISSIONER ERICKSON: It was foundational to supporting the improved engagement of the consumer in the health system, not foundational to -- well and also foundational to improving the whole system, but the intent really was to focus on those areas that would support improved consumer engagement and that some of the other policy issues would be captured under statewide leadership. Val?

COMMISSIONER DAVIDSON: It's discussed on page 25 of our report.

COMMISSIONER ERICKSON: Yes, it is. So what if we take

Wes' suggestion and if folks want to, we could allocate time right now, just make a placeholder on the agenda, allocate time at our next meeting to spend discussing the overall transformation strategy and accept that we may have a missing piece and that anybody who has suggestions that they want to float to the group before that meeting for improving this picture and bringing the missing piece in, and you know if the ideas that came up this morning want to be revisited, we could do that, too. I don't mean to dismiss those ideas, but let's take a month to think about it, offer some suggestions and then spend some time focusing on it at our next meeting. Does that sound like a plan? I see lots of nodding heads.

And so the last piece I wanted to revisit then before we move on is the work that we had laid out at the end of the last year for this year, and this was assuming that would have a full year's worth of work. But the initial Commission at the end of the first year identified a continuing concern about cost of health care and not having enough information yet about the disparities in cost of care in Alaska between other areas, a concern about what might happen at the federal level and wanting to be able to analyze that. This isn't in your -- I added this. This was in your presentation yesterday morning that I gave. It's not in the one that you have in your notebook for this morning. I just added it on the break.

If you wanted to look at the report, I think it's on

page.....

UNIDENTIFIED COMMISSIONER: Isn't this the slide the one we had right here? (Indiscernible - away from mic) page 13.

COMMISSIONER ERICKSON: Yes, page 13 of that handout or page 69 of the Commission's 2009 report. So this is just meant to frame what we're going to do next, if this is what we wanted to focus on as a work plan for 2010, if the Commission wants to continue studying and understanding, if they feel as though they need to better understand why cost of care in Alaska is different, higher than other areas, if the Commission wants to spend some time and resources analyzing the impact of federal legislation on our health care system. Tracking implementation of the 2009 recommendations is something that I'll just do automatically and included in the next report and bring information to the next meeting on it as well. But the big piece that we need to figure out is, what are the strategies that we think are the most important to focus our time and energy and money on over the next three months and over the next 15 months. Does anybody have any questions about that?

Well hearing none, I'll go back to the slides that we had laid out before. So I'm on slide three in your handout. What we were going to spend the rest of the morning talking about so we can kind of set our agenda for the next meeting and our work plan for the rest of the year is identifying areas where

you feel like you need more information, more study, a consultant to better understand how the health care system is working and what the issues in the health care system are right now. Yes, Jeff?

COMMISSIONER DAVIS: Thank you. Well on page 69 of our report that we just referred to, the first item is what you had up there, analyze variations in pricing and resulting cost shifting. And what we had said at that point is we need to use some of our money -- now that we have money -- to hire a consultant to study this. We have been asked various times for information around comparative costs, comparative prices actually, by the Division, by the Medicaid task force, by others, and we provided that, but I don't think there is any comprehensive analysis that's been done that looks at, you know, worker's comp and Medicaid and private insurance and kind of what says where are we and why are we here and what maybe needs to change to get us out of the spot that we're in. I just don't think we have a real thorough understanding of that, and we can't -- unless you know where you are and where you want to go, you're liable to end up someplace else. So I highly recommend we spend some of our money on having that done by an objective third-party.

And in addition to that, there is sort of a related question that I have had over the years and have heard a number of physicians talk about the struggle to serve Medicare

patients at the current reimbursement. And you know, I hear that and believe it; I'm just not sure I fully understand it. Is it because, somehow, Medicare -- and I should know this, but I don't because we don't do Medicare business. So I'll just put my ignorance out there. Is it because -- there lots of hypotheses. Is it because Medicare pays less here relative to the cost of labor? Is it because, somehow, there are requirements of Medicare here that are different than elsewhere because there are different places in the country where physicians thrive on Medicare, and clearly, that's not what is happening here, you know, based on you've said.

So I'd just like to understand that better because we can't -- again that was one of our major concerns from the work of the Commission last year. Until we kind of understand why isn't this working, we can't find our way out of it. So I would like to see us use our consulting dollars to probably -- maybe with one contract with two pieces to look at those two aspects of costs here. Thank you.

CHAIR HURLBURT: Could I ask what kind of expertise would you hire? If you're looking at rate setting, you're going to hire an actuary. If you're looking at macroscopic economic analysis, we'd get somebody like Mark yesterday. But neither of those folks would have the expertise to deal with relative pricing issues and cost issues.

COMMISSIONER DAVIS: Well I -- just in general, I would

look towards one of the major actuarial firms who, yes, they do look at risk and rating and those sorts of things, but they also are very good at doing comparative analysis and adjusting for things that the layperson might not know. So someone like a Milliman, I would look to, but I would want to be very specific about what it is we are looking for from them. You know, we want to know, why is, you know, the cost for a knee arthroscopy -- an example that's been put out here -- $4,000 in Anchorage and $800 in Seattle? Why is that? You know, are there good reasons for that? You know first of all, what's the picture? You know, where do we see these variations? Where do we see things that do make sense to us, and you know, isolate that then try to say why, what is that, and then what's the way out? That's what I would like to see, but I'm going to be very specific with them about that. And so it's not -- it is the cost per unit that I'm mostly interested in personally as we look at this question because that's where we have this huge discrepancy. Thank you.

COMMISSIONER FRIEDRICHS: And I think that's an excellent point that you raise. We're using Milliman to do exactly that sort of an analysis on the federal side right now because you're right; that's important to understand the way ahead and to determine where we want to go with rates. It does not, unfortunately, get in any way into the quality aspect of it. They'll only look at the quantity and the cost per unit, but

that seems to be the organization that's best equipped to do it. There is another firm called Kennal & Associates.

COMMISSIONER ERICKSON: Paul, I didn't hear what you just said, the second organization?

COMMISSIONER FRIEDRICHS: Kennal & Associates.

COMMISSIONER ERICKSON: Kennalon?

COMMISSIONER FRIEDRICHS: Kennal, K-e-n-n-a-l, I think. But that's the only other group that I know of that has been able to do the sort of macro level analysis that you're describing on a contract basis at a system level. So I agree with you that those are two important discussions to answer, and as individual, not speaking as a federal representative, Milliman has demonstrated the ability to do that in the past for us.

COMMISSIONER ERICKSON: Jeff, I'm sorry. Could you restate the first point on the cost study?

COMMISSIONER DAVIS: Sure. We have heard testimony. We've seen limited evidence that suggests that, at least in some parts of medical practice in Alaska, the price -- we're talking about the price. The price is significantly different in Alaska for certain services than it is elsewhere in the country, and I would like to, first of all, understand what is fact and fiction around that and then some analysis of why, how did we get there, and then some thoughts about where we would -- the way forward from there. Thank you.

COMMISSIONER BRANCO: Yesterday after Mark Foster's presentation, I was overwhelmed with data, but I found myself lacking information as I sat in the hotel room last night. And one question that he was asked intrigued me, and his answer intrigued me more when the biggest factor that he saw was workforce. And what I contemplated all night was the two sides of that, where he was mentioning the fact that it's going to be costly to achieve the goal of getting enough providers and a support system to care for the increased access, but I don't know the real cost of the success of that. So if we achieve that goal or partially achieve that goal, I'd like a little further or deeper analysis on that.

The other piece is if we don't. If we come up short, if we have alternative approaches to primary care, if we use more physician extenders, and I think there are going to be regional differences, and I'd love to see more data, but some more complete information on that would help me.

COMMISSIONER ERICKSON: Val, is this specific to Pat's point? Can you hold on to it for just a minute because I don't -- I want to make sure I fully understand what you're asking for, Pat. Can you just restate it?

COMMISSIONER BRANCO: No, that's about as good as I can do. There is a cost to success. If we engage, recruit, retain.....

COMMISSIONER ERICKSON: To success in improved retention

of or increased supply of workforce?

COMMISSIONER BRANCO: Yes. Achieving the right balance of providers to accommodate the people who will need access to care, so that's recruitment/retention, and most particularly recruitment. There's a cost to that. If we need more providers tomorrow or the year 2019 as was forecast, I really need to look at a dollar amount that would measure that success.

The second piece is, not achieving that success, what's the regional impact going to be? And it's just a little bit more analysis and speculation. I know it's not information. It's more data and speculation.

COMMISSIONER ERICKSON: So is the question, how do we measure success?

COMMISSIONER BRANCO: No. Well no, I think that one's going to be okay.

COMMISSIONER ERICKSON: In terms of workforce? What's that?

COMMISSIONER DAVIDSON: It's the cost of success.

COMMISSIONER BRANCO: That's what I was saying, the cost of the success. Each new physician hired over the next nine years is going to have a cost. That cost is going to be borne by the system that we developed and so the price of success will also offset the cost of care, and so I need to have a little deeper analysis of what that cost potentially could be

with some forecast on salary improvement. We're talking about paying primary care docs at a rate that they should be paid. Recognizing their contribution to the health care system, I don't think we're going to get them at $125,000 a year anymore. It's not going to happen. So I'm really trying to project where that may go and then how that cost will eventually be balanced, and I'm also realistic, understanding that, achieving that goal, we may come up short, and we're going to have to address other approaches, most especially out of our urban areas and that that cost ratio may be different. So I'd like somebody's better guess than mine.

COMMISSIONER ERICKSON: Cost of success of workforce development, but success being improved recruitment and retention?

COMMISSIONER BRANCO: Yes.

COMMISSIONER FRIEDRICHS: If I may, the Alaska Health Workforce Plan really lays out in great detail some of the steps which need to be taken.

COMMISSIONER BRANCO: I helped write it.

COMMISSIONER FRIEDRICHS: And I commend you for that because, you know, it really does get to some of the steps. And you're right. When we looked at this from the federal standpoint, we said and what's the price tag.

COMMISSIONER BRANCO: Correct.

COMMISSIONER FRIEDRICHS: What would it cost for us to

implement the recommendations that are in here and that's not addressed in here, and that's part of what, you're right, I think several of us were trying to drive towards in the question again. His answer seemed to indicate that, if you're willing to hire me, I'll work through those issues for you and give you a good estimate, but I haven't done it yet. But this is a great flight path, track, whatever you want to call it to get us to an improved workforce, and costing out what it would take to the do different aspects of this would be helpful data, I suspect, to incorporate into our report to the Legislature, at least give a menu to say that building a medical school by 2020 is going to cost the State this amount of money. And if you do that, you typically retain 60% of the docs who were trained there, which means that you would save on recruiting costs, increase your supply, and here is the cost benefit analysis for a medical school versus doing a loan repayment program where you might get, in theory, a short term bang for the buck. However now that all 49 other states are doing loan repayment, it turns out there aren't that many people who are signing up for it. That's the sort of analysis, I believe, that you're driving towards. Is that a correct understanding?

COMMISSIONER KELLER: A comment, if I may? I wish Mark were here, but I think he was talking about more than doctors. I mean, that's just one very narrow -- and if we ask for a

consultant to do some work through this, I think there's some interesting parameters that we've got to think about on that because one type of workforce expansion might -- you know, what is a success? I mean in other words, we've got to somehow to ask what we're asking for or set parameters around what we're asking for.

COMMISSIONER ERICKSON: Noah and then Ward?

COMMISSIONER LAUFER: Two quick things. You know, we operate at a much smaller scale, but I told Wes yesterday how I think about this. If you want to recruit doctors, you could pay for medical school and residency and hope and pray that they want to stay in Alaska after being to the big city. I'm thinking, you know, a little bit more guerilla style warfare. I call a residency and I say, hey, I know your third years are productive now and it costs you money to lose them. We'll cover the cost to a couple thousand dollars for them to do a six-week rotation in Alaska. And then they come up, and we wine and dine them and take them skiing and whatever. That's way cheaper, and the State could do that. We could say we will pay the cost of losing your third year productive resident for six weeks if they want to come to Alaska. We're stealing other states' resources, but I think that's fine. They'll get the same -- they'll have the same idea.

The other thing for Jeff, you know, I'm thinking -- I go back and talk to my partners and I said, wow, the State -- you

know, we paid however many tens of thousands of dollars and the experts came in and they said that you can make money seeing Medicare patients. They're not going to care. The reason nobody is seeing Medicare patients in Anchorage is you can't make money doing it. I mean if there is a capitalist incentive, they would do it. The study has actually been done. George Rhyneer has looked at it. There is a model, but it's very, very high volume. And I think that's -- you know, it doesn't matter, really, what an analyst says. The cost of a nurse is so much in Anchorage, and the cost of all of that is -- not only is it expensive to do at the residency which capped the number as a federally funded -- you know I mean, you couldn't be in a better position -- or at Anchorage Neighborhood Health which is going to build a new building three times the value of ours. I have to cover the rent, our insurance, the health insurance for our employees, you know hopefully retirement, all of that stuff. It isn't going to impress me to hear that it's unaffordable. We probably could do it if I changed the model, but we're talking substantial change. Thanks.

COMMISSIONER DAVIS: If I just could clarify, I do not debate that you can't make money on it. What I want to understand is why and again the hypotheses because the conventional wisdom is there are physicians elsewhere in the country who are making money on it, and I don't think they're

doing with the Rhyneer style clinic.

UNIDENTIFIED COMMISSIONER: I hope not.

COMMISSIONER DAVIS: I hope not either. So I just want to know the difference because maybe that would give us some clues about how we could solve the problem here, but I do not debate the fact that what everything you say is true. I've heard it way too many times. Thank you.

COMMISSIONER ERICKSON: Ward?

CHAIR HURLBURT: Yeah. I think Pat makes a good point on the manpower study that we do need to add the cost part to that equation, and perhaps you were suggesting that Mark could help us with that, based on the work that he has done. I would want to incorporate in that -- because if you use Mark's numbers -- and I can argue that they're understated, but accepting Mark's numbers of $7.1 billion now, that puts us at 23% already of our GDP in this state for health care compared to the rest of the country. And the numbers are usually a little lower, but I believe from what I read from CMS it's at 18%. We're still 5% more. That's a lot more than the rest of the country. So I think we need to keep that context there. Also I think Mark, as an economist, has diligently tried to stay away from any value judgments and getting into that area, but I think that needs to be a part of how we're looking at it overall on what our costs are.

COMMISSIONER BRANCO: Can I just respond real quickly?

COMMISSIONER ERICKSON: Just real quick and then we'll give Val a chance.

COMMISSIONER BRANCO: I understand. And just quickly to Ward and to Wes that this is the entire workforce complement. Dr. Laufer mentioned yesterday the impact of one physician on one community and the jobs created in that element. So yeah, it is more of a global view.

COMMISSIONER ERICKSON: Thanks. Val?

COMMISSIONER DAVIDSON: I want a better idea of what exactly is the problem that we're trying to solve, beyond just cost. So in Alaska of our population that we have here, what are the leading causes of death, what are the leading causes of hospitalization, primary care visits, and where are we spending our money? Not just Medicare, not Medicare. I mean, it's everything.

CHAIR HURLBURT: Can I respond on that, Deb? I'd say our whole purpose of being here so that's it not just cost -- we're concerned that it not be cost. If it were not for cost, if it were not only for cost, we wouldn't be here. That's, I believe, what is driving us to be here. Our opportunity is to make sure that it's not just cost, that we have the quality issues, that we have the other things there. But if we were still spending 10% of our GDP on health care, we wouldn't be here, I don't believe.

COMMISSIONER DAVIDSON: I'm not going to get into that

debate with you because we could go on for hours, so I won't. So again I'd like to clarify exactly what the problem is that we're trying to resolve. So if we don't have a sense of -- and we hear lots of information about cost and we hear all the reasons why, but we're not talking about what it is that we're trying to fix. So what are the leading causes of death? What are the leading causes of, you know, what are our health disparities compared with other populations, et cetera?

And you know, I keep thinking about the whole concept of cost, and it's not necessarily the high cost. It's what people are willing to pay for. So for example, it used to be that you could buy a really good TV for $200. And now plasma and flat screen TVs will set you back $600 to $1,000, and it's become the new norm. Everybody wants a flat screen TV. And so a part of is -- so everyone thinks flat screen TVs are wonderful and fabulous, but to me, it just means that a whole bunch of people got out-priced for the cost of a TV. Are they willing to pay for it? Absolutely. So it's more than about cost. It's value. But I really want to get a sense of if we have -- because honestly the cost that we spend on health care is to address our health disparities. It's what are people presenting for. Is it because we don't have enough clinics that are open on Saturday and so people are using the emergency room? Is it because people aren't getting primary care, and so therefore, they're waiting until they need a

Medivac? Is it because we haven't adequately addressed the costs? Is it because we haven't adequately addressed the behavioral health needs of our communities, so we're seeing increased rates of suicide, we're seeing increased costs of the costs associated with treating people who've committed violent crimes because they might be jacked up on a variety of drugs, et cetera?

My point is, I want to know what it is that we really -- what's the problem that we're actually trying to solve? We say that we're spending a lot of money to provide care, but what is the care that we're buying?

COMMISSIONER ERICKSON: So your question is, what is driving the increased costs, increasing costs and higher costs?

COMMISSIONER DAVIDSON: It's both. I'm sorry. I'm not being very clear. Let me back up and try again. I want to know what our health disparities are in Alaska. So for example, if our number one health disparity is dealing with complications of diabetes care, absolutely, that should be where we -- one of our recommendations. If on the other hand one of our highest health disparities is suicides or alcohol-related illnesses or injuries or et cetera, then maybe we should look there.

So it's a part of, one, what are our health disparities? That's one part. So what are our rising trends? Are we

seeing increased rates in cancer or diabetes or behavioral health issues, et cetera? So that's sort of the what's needed. The other part of it is, what are spending our money on right now? And those are two different things. I'm sorry I'm not being very clear.

COMMISSIONER FRIEDRICHS: No, I think you're being very clear. When we did the federal commission, that's exactly the approach that we took was trying to work through the data that defined the problem, and it turned out that mental health was a significant disparity in Alaska, unlike other states or to a greater extent than other states. Specialty care is where we're spending a lot of the money because we don't have a great primary care system, in part we believe. Some of that work has been done. I'd be happy to share it with the group, and we've captured some it in our report here that's under tab eight. But I can share with you some of the data that we've pulled already, if that would be helpful.

COMMISSIONER ERICKSON: Emily?

COMMISSIONER ENNIS: Thank you. I'd like to tag on to the behavioral health and mental health needs and getting more information about the impact on our state. Primary care is overrun with behavioral needs. The behavioral health centers are having increasing waiting time to get in for treatment. That results in people ending up in the ER, higher costs. Even apart from our identified behavioral health patients, we

have young folks with autism that are really impacting family and community and school lives. We have our seniors with dementia that also are exhibiting behavioral health needs. So all over the board, we're finding a greater and greater impact and greater cost as some of the secondary results from behavioral health needs result in poor physical health care, development of other conditions that are also costly, up into suicide. So I do believe we need to have more accurate information about the status of behavioral health needs in our state, and what are we doing on a statewide level to provide a structure and greater level of expertise?

COMMISSIONER ERICKSON: Go ahead, Wes.

COMMISSIONER KELLER: Wayne left. That's too bad because I had just one little aspect to this thing. Analyzing the cost of health care in Alaska has a very significant, as we all know, economic development. We're rated the highest workman comp rate in the nation. And you know, figuring out how to address those things, this cost analysis, I would think, would be very helpful. That's all. Not just insurance, I mean, it's just the big picture.

COMMISSIONER ERICKSON: So I'm feeling as though we need to wrap up this conversation. We only have five minutes and didn't even get to our second main question, but that's okay. It might not feel okay, but trust me, it's okay.

So we've identified three, maybe four, but Val, I split

yours into two areas, cost of care, specifically price variations and then more specifically the Medicaid rate question, why -- Medicare. Thank you. That is what I meant. I knew what you said. I just didn't write what I meant. Workforce, the cost of success, and recruitment and retention, and then leading causes of death and health disparities, what are our health problems in Alaska, and then where are we spending our money related to both the cost and the health issues. And then Wes, you were just wrapping up saying the big picture in terms of costs.

Maybe a specific decision we can make now whether it's yes or no is I had included in your packet and asked you to review, just trying to anticipate what some of the ideas might be for how we can spend some of the consulting money and jumping off from the questions about cost at the end of our last Commission wrap up.

I did go ahead and ask Scott Goldsmith for a couple of proposals. Scott is the principal economic analyst with ISER, the Institute for Social and Economic Research at the University. And one benefit of working with them -- I mean, they're the economists -- and he works with Mark as a subcontractor -- who have studied health care costs in the State on a more macro level in the past. So I provided the most recent they had done from five years ago.

So would that -- I know that's not the same as what you

were suggesting in working with an actuarial on the pricing variation. So my first question is following up on Wes' suggestion, another aspect of costs at a macro level, would you like to have an update of the macro level cost questions similar to -- and we can work on tweaking some details with just getting some ideas from you over email and have me go ahead and put a contract in place with ISER to do that? I see a few nodding heads.

COMMISSIONER DAVIS: I guess I'd want to know -- excuse me.

COMMISSIONER ERICKSON: Go ahead.

COMMISSIONER DAVIS: I want to know exactly what we're going to get from that. I think Val is asking the right questions about the macro view. So if what they were putting together as an update was more around, you know, specifically looking at those areas, that would be great. I think we need to understand that. It's very different than what I was interested in, but also very important.

COMMISSIONER ERICKSON: I know it's different from what you -- right.

COMMISSIONER DAVIS: I mean, just re-doing the study that was done five years ago, I don't think, gets us what we need. Thank you.

COMMISSIONER ERICKSON: So what if I go back and work with them and see -- I'll work on defining an adjusted scope

of work with them that's more based on Val's point of where the money is going, what it's being spent on. Does that make sense?

UNIDENTIFIED COMMISSIONER: (Indiscernible - away from mic)

COMMISSIONER ERICKSON: Right. So I'll do some more work on that and bring that proposal back -- bring another proposal back to you for the next meeting. Does that make sense? And I'm a little concerned about what we have for money in working with Milliman, but I'll do some investigation there just to give us a sense.

CHAIR HURLBURT: Could you look at the scope of work? Are you able to share that? And is that on a national basis or is that Alaska?

COMMISSIONER FRIEDRICHS: Specific to Alaska.

COMMISSIONER ERICKSON: So maybe I can follow up with Paul.

CHAIR HURLBURT: Yeah. Probably the report will be a public document, will it, discoverable?

COMMISSIONER FRIEDRICHS: It will be discoverable certainly, but the VA was the initial funder for the research. DOD is now looking at partnering with them to look across federal funding streams, but the good news is they will have already begun to look at this market in detail because of this contract. And so I think that's one more reason why Milliman

is a good choice to potentially look at, but we can talk offline on that.

If I may, the other suggestion I would make is, you know if you're going to re-scope what you think you heard today, certainly other groups I've worked with have been able to use email as a way of passing something out beforehand and not waiting for a month for us to look at it. So that might be an option also to send it to us, if the rest of the Commission is willing, and then we can say yes, this is it or not.

COMMISSIONER ERICKSON: Sounds good. And we need to do some more work on fleshing out and prioritizing these, but we'll continue working on that over email and at the next meeting and see if we can move at least one or two of the pieces along more quickly.

The other thing we were going to address this morning that we don't have time to now are those strategies that we want to start studying more in-depth.

First of all starting with evidence-based medicine since you've had some learning around that, what would like to pursue in terms of a next step related to that? Yes, Pat?

COMMISSIONER BRANCO: Start with changing the recommendation on the second to the last slide of Dr. Hurlburt's presentation this morning, and one is Dr. Laufer touched on the point of there is not evidence for everything that we do in practice. So taking the evidence-based approach

with a graded.....

COMMISSIONER ERICKSON: I'm sorry. Can I interrupt you, Pat?

COMMISSIONER BRANCO: Yes.

COMMISSIONER ERICKSON: Just in the interest of time.

COMMISSIONER BRANCO: Of course.

COMMISSIONER ERICKSON: I wasn't suggesting that we work on the recommendation right now. I would like to follow up at the next meeting and include it on the agenda. And so my question is, one -- the first question is, you want to continue the conversation about evidence-based management.....

COMMISSIONER BRANCO: Correct.

COMMISSIONER ERICKSON: .....as a strategy and include it on the agenda; that's the first question.

COMMISSIONER BRANCO: Yes.

COMMISSIONER ERICKSON: Yes. I'm hearing yes. And then the second question.....

COMMISSIONER BRANCO: And I'll email you something.

COMMISSIONER ERICKSON: .....is, do we want to work over email suggestions for an improved recommendation to include in the report related to evidence-based medicine? And I'm seeing people are putting their thumbs up and nodding yes.

The third question is -- and since we're not even really doing full consensus, I'm assuming that if folks are disagreeing you're going to speak up and not complain later

after the meeting, and just in the interest of time and keeping us moving along. And the third question is, do you need more information before the next meeting or do you feel like you understand enough at this point about evidence-based medicine? So I'm seeing folks heads nodding about that. Very good.

Are there other strategies you want to make sure we include on the agenda that you can just name off real quickly right now? Otherwise, we'll follow up over email.

COMMISSIONER FRIEDRICHS: Well I think, if primary care is going to be our focus, having Doug Ebby or someone come in and talk about what has actually been accomplished in the primary care arena so that folks -- everyone on the Commission understands what progress has been made would be helpful. You know, Ken Kaiser is going to be in town next week doing a presentation on the VA primary care -- I think they're calling it renovation or something like that, but transformation. I mean, there is a lot of work that has been done, and rather than all of us trying to brainstorm to figure out what the lessons learned are, that work has already been captured and we should perhaps bring that forward and then choose from those lessons learned what we want to incorporate in a report back this year, again if that's going to be our focus.

COMMISSIONER ERICKSON: The group did have Dr. Ebby present at one of their learning sessions that supported the

recommendation that was included in the 2009 report. So would we ask him to get to another level of detail in this subsequent presentation or help the Commission come up with some more specific recommendations for moving forward?

COMMISSIONER FRIEDRICHS: I mean, my personal bias and frustration on the federal commission was the difficulty in getting to very granular specific -- the next three things we should do are X, Y, and Z. When I read through the report from last year, there is a lot of great information. But like our Commission, we did a wonderful job defining the problem and saying that we need to do better on quality, we need to better on primary care, we need to do better on life as we know it.

COMMISSIONER ERICKSON: So you would specifically like us to bring Dr. Ebby in to help formulate the next step, the next level down, more specific recommendations on moving the innovative primary care model forward? Thoughts on that?

COMMISSIONER FRIEDRICHS: I mean, my recommendation would be bring in both Dr. Ebby and Ken Kaiser or someone from the VA who has been doing this for a while to say these are the strategies which have worked for us and here's the outcomes. These are the ones that sounded really good but turned out not to be of any value and then we incorporate that as a Commission into these are things we ought to be going after.

COMMISSIONER ERICKSON: Noah?

COMMISSIONER LAUFER: I think there is some severe failings of the systems for both of these guys, and you just need to go over and look at the campus required for SouthCentral and count that into health care costs, you know a parking garage that would cover our overhead for ten years. However, they do have a great strength. And the classic example is this management of diabetes, and it is a tangible. You can define it clearly, and the rest of the community could learn a lot from what he's done. When I've heard him speak, I don't, you know, agree with a lot of it because I know the turnover of the physicians is extremely high. They can't keep them for more than a couple years. I have, this year, had eight doctors contact me asking if they could flee the ship. So there are absolute problems, but that's why I like diabetes. I'm exposing our biggest weakness because I'd like to improve it, but this has to be taken with a grain of salt, or ten.

COMMISSIONER MORGAN: Don't look worried. It's going to be okay. Another person that we might want to consult who has addressed this issue but on an independent physician level is Steven M. Shortell, S-h-o-r-t-e-l-l, at the University of California at Berkeley, and he's written extensively of expanding forms of this into physician groups and independent physicians. I think you're correct in one way that, in Alaska or anyplace, there is not going to be a magic bullet. There

is going to be a whole lot of different solutions to do the things that we are going to want to do, but I would suggest contacting him. And I have his stuff here. I'll give it to after that. And he has written extensively on Accountability Care Organizations and the stuff we're talking about, but he always has a part that deals with what you're talking about and has studied that.

COMMISSIONER ERICKSON: Shortell.

(Pause - background discussion)

COMMISSIONER ERICKSON: So we have issues. I think I'm hearing agreement. I think I'm hearing agreement, understanding that we are not having a full-blown discussion session here, that we want to work on next steps around improving the primary care model but not necessarily agreement on the best consultant to bring in to support the development of recommendations for the next step. But having the first piece is good enough to move forward. We'll see if we can identify and get some agreement on the consultant that we think would be best to support development of that recommendation. And we're needing to wrap up. So I apologize. We didn't really accomplish what we were going to accomplish this morning, but I think it was very, very important for our new members and I'm still feeling as though we could spend some more stepping back for their benefit and regrouping on where we're at and where we're going, but it's

all good. This pain is worth it, will be worth it over time, hopefully in folks feeling some ownership in developing our products.

So what I'm going to do since we weren't able to have a full conversation about those other strategy areas that you might want to identify as a priority for continued study or that you might feel ready to start developing some recommendations at the next meeting, I'm going to put out a couple of different emails listing some suggestions and ideas and seeing what your response might be.

And I have one final question. I had included in your packet a proposal from ISER, a second proposal from ISER that would have ISER work with Mark Foster on finalizing and kind of -- the report that he's been doing, that he's been working on his own, he would work with Scott on vetting that and putting it into a formalized report to the Commission, and it would meet that second bullet on what had been an idea for a 2010 work plan to do some analysis on the impact of the Affordable Care Act if it passed on the State. Do you see value in that?

I see three heads nodding, four heads nodding, five, six. Does anybody disagree?

COMMISSIONER DAVIS: I'm sorry. I checked out and went someplace else for a few minutes mentally. I'm sorry. Could you please say exactly again what you were hoping to have them

do? I'm sorry. I apologize.

COMMISSIONER ERICKSON: Essentially take the analysis he has done so far that we saw -- yes?

UNIDENTIFIED COMMISSIONER: Is this what you're talking about?

COMMISSIONER ERICKSON: Yes. It's -- there is a memo dated September 28th from Scott Goldsmith of ISER to me, Preliminary Review of Economic Impacts of Federal Health Reform for Alaska. So it will provide an opportunity to kind of put it through ISER so that there is more of a review, other economists looking at it and formalizing and finalizing it in report form so it's not just a chart pack.

COMMISSIONER DAVIS: So the part I was here for heard that. So I think there's some additional work that I'd be really interested in that's not in this macro view and that is some more work around what does this mean on the street to an insured Alaskan. I mean, Mark had the one slide that dealt with one aspect which was the change in the minimum benefit package, but it didn't consider adjusted community rating and those sorts of things. And I think that we need to understand that.

COMMISSIONER ERICKSON: So that's another question that needs to be answered. ISER is not necessarily the right group to answer that question, or do you think they might be?

COMMISSIONER DAVIS: I don't know. I can't comment on

that.

COMMISSIONER ERICKSON: Well I will ask them that question as a starting point. And one of the benefits of working with ISER as another government entity, we can contract with them directly if we think that they are the best folks to ask to do the work rather than going through a procurement process that will take several months, essentially.

COMMISSIONER DAVIS: If they could do that, I think that's great because I think one of the values of is it's an independent analysis. It's not what I think. It's not what one of our Senators thinks. It's what ISER has thought. But someone needs to -- I believe it's important to say, what is this going to mean to Alaskans in 2014 who are buying a policy? Thank you.

COMMISSIONER ERICKSON: Very good. I will add that to the list. Well I think we need to wrap up for the morning, and one thing I like to do at the end of a meeting is just take a few minutes to evaluate without doing a formal evaluation form, see what folks liked about the meeting, see what suggestions you have for making it go better next time. Could we do that in just last two minutes and then confirm our next meeting dates of November 16th and 17th? Yes, Jeff?

COMMISSIONER DAVIS: Thank you. So for the five who weren't here in the beginning, when we developed a job

description for the Executive Director, we were very clear, the original Commission was, that one of the things we wanted was to be driven, that a passive Executive Director would not work because we wouldn't move forward. And so I appreciate the fact that Deb makes us a little uncomfortable sometimes and pushes us forward because, I think, the work of last year reflects that, and I just wanted the other Commission members to know that we asked her to do that. So it is with our permission and blessing that she does that. Thanks, Deb.

COMMISSIONER BRANCO: Oh wait. That says increase the pushy director. Increase the level of pushiness. I wanted to add very quickly that the homework assignments in preparation for the meeting were right on, and feeling pushed there was exactly what I need as well in a busy schedule and also focus there.

I have one second comment. That's to commend the work of the original Commission. This is incredibly good work, and it really lays a solid foundation for this going on forward.

COMMISSIONER LAUFER: I appreciate what Val has done for us, and I think -- it is possible to spend five minutes at the beginning of each meeting reviewing what the directive is from the Legislature, like you know, this is what we're actually here for?

COMMISSIONER ERICKSON: Sure. Absolutely.

COMMISSIONER LAUFER: It's a good way to get started. If

we're going to get it done, we have to remember what we're doing.

COMMISSIONER ERICKSON: Other ideas for improvement?

COMMISSIONER CAMPBELL: I don't have any idea for improvement, I don't think, but I just want to complement the appointment of these five shrinking violets to this Committee. It's been a pleasure to get off the pad so fast with these people.

COMMISSIONER ERICKSON: Yes, Val?

COMMISSIONER DAVIDSON: So I think something I thought that was missing from this meeting and maybe we could have it at the next one is, what are some of the initiatives of this Administration in terms of health care because I feel like there are things that are happening parallel or completely outside of this discussion, and I just think it would be helpful to know what some of those things are, so that if they have any bearing on the outcome of what we're recommending, I think it would be really helpful. I think sometimes it's a surprise to me to hear about them in other avenues.

COMMISSIONER ERICKSON: We can do that. Other suggestions for improvement or requests for agenda items for the next meeting? Very good. Well thank you all very much for your time. I'll do more of a kind of a wrap up next steps over email for you. Thank you.

12:02:12

(Off record)

END OF PROCEEDINGS